Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

SECOND STATE FISCAL QUARTER 2016

October, November, December 2015

Robert J. Harper
Superintendent
January 22, 2016

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STRATEGIC PERFORMANCE EXCELLENCE

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Glossary of Terms, Acronyms & Abbreviations

ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CH/CON	Charges/Convicted
CMS	Centers for Medicare & Medicaid Services
CIVIL	Voluntary, No Criminal Justice Involvement
CIVIL-INVOL	Involuntary Civil Court Commitment (No Criminal Justice Involvement)
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
DCC	Involuntary District Court Committed
DCC-PTP	Involuntary District Court Committed, Progressive Treatment Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off Communication
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
JAIL TRANS	A patient who has been transferred to RPC from jail.
JTF	A patient who has been transferred to RPC from jail.
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	Licensed Practical Nurse
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NASMHPD	National Association of State Mental Health Program Directors

NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner
NPSG	National Patient Safety Goals (established by The Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OPS	Outpatient Services Program (formally the ACT Team)
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications
PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
PRET	Pretrial Evaluation
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RPC	Riverview Psychiatric Center
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability. Staff Development.
Seclusion, Locked	Patient is placed in a secured room with the door locked.
Seclusion, Open	Patient is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)

Introduction

The Riverview Psychiatric Center Quarterly Report on Organizational Performance Excellence has been created to highlight the efforts of the hospital and its staff members to provide evidence of a commitment to patient recovery, safety in culture and practices, and fiscal accountability. The report is structured to reflect a philosophy and contemporary practices in addressing overall organizational performance in a systems improvement approach instead of a purely compliance approach. The structure of the report also reflects a focus on meaningful measures of organizational process improvement while maintaining measures of compliance that are mandated through regulatory and legal standards.

The methods of reporting are driven by a nationally accepted focused approach that seeks out areas for improvement that were clearly identified as performance priorities. The American Society for Quality, National Quality Forum, Baldrige National Quality Program and the National Patient Safety Foundation all recommend a systems-based approach where organizational improvement activities are focused on strategic priorities rather than compliance standards.

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measures described in the Order Adopting Compliance Standards dated October 29, 2007. Comparison data is not always available for the last month in the quarter and is included in the next report.

The second section describes the hospital's performance with regard to Joint Commission performance measures that are derived from the Hospital-Based Inpatient Psychiatric Services (HBIPS) that are reflected in The Joint Commissions quarterly ORYX Report and priority focus areas that are referenced in The Joint Commission standards:

I. Data Collection (PI.01.01.01)
II. Data Analysis (PI.02.01.01, PI.02.01.03)
III. Performance Improvement (PI.03.01.01)

The third section encompasses those departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence. Several departments and work areas have made significant progress in developing the concepts of this new methodology.

As with any change in how organizations operate, there are early adopters and those whose adoption of system changes is delayed. It is anticipated that over the next year, further contributors to this section of strategic performance excellence will be added as opportunities for improvement and methods of improving operational functions are defined.

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CONSENT DECREE

Consent Decree Plan

V1) The Consent Decree Plan, established pursuant to paragraphs 36, 37, 38, and 39 of the Settlement Agreement in Bates v. DHHS defines the role of Riverview Psychiatric Center in providing consumer-centered inpatient psychiatric care to Maine citizens with serious mental illness that meets constitutional, statutory, and regulatory standards.

The following elements outline the hospital's processes for ensuring substantial compliance with the provisions of the Settlement Agreement as stipulated in an Order Adopting Compliance Standards dated October 29, 2007.

Patient Rights

V2) Riverview produces documentation that patients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement;

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Patients are routinely informed of their rights upon admission.	95% 57/60	100% 45/45	100% 79/79	80% 16/20

Patients are informed of their rights and asked to sign that information has been provided to them. If they refuse, staff documents the refusal and signs, dates & times the refusal.

V3) Grievance tracking data shows that the hospital responds to 90% of **Level II** grievances within five working days of the date of receipt or within a five-day extension.

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Level II grievances responded to by RPC on time.	N/A	100% 1/1	100% 1/1	N/A
2. Level I grievances responded to by RPC on time.	98% 96/98	52% 45/86	78% 129/165	51%* 49/97

*48 grievances were not responded to on time or cannot be accounted for.

CONSENT DECREE

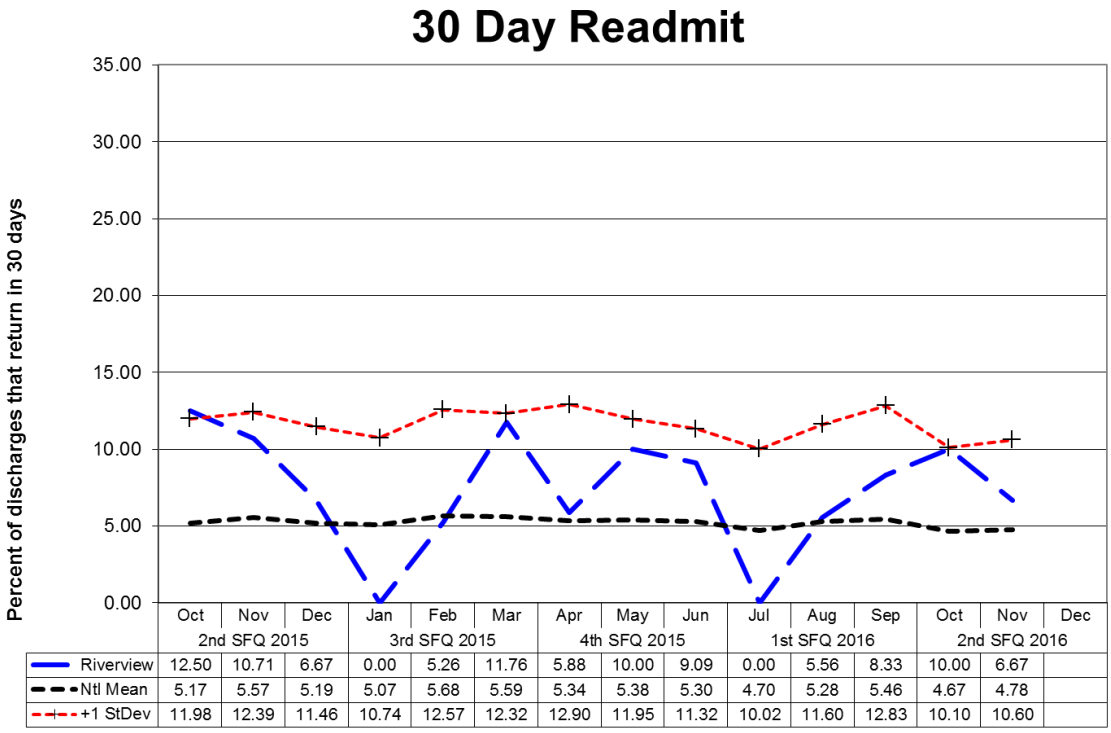
Admissions

V4) Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria;

ADMISSIONS	3Q2015	4Q2015	1Q2016	2Q2016	Total
CIVIL:	**26**	**25**	**30**	**37**	**118**
VOL	0	1	2	1	**4**
CIVIL-INVOL	3	2	4	5	**14**
DCC	22	20	23	31	**96**
DCC-PTP	1	2	1	0	**4**
FORENSIC:	**17**	**20**	**34**	**21**	**92**
60 DAY EVAL	3	6	19	11	**39**
JAIL TRANS	0	0	2	1	**3**
IST	5	13	6	7	**31**
NCR	9	1	7	2	**19**
TOTAL	**43**	**45**	**64**	**58**	**210**

CONSENT DECREE

V5) Quarterly performance data shows that in 3 out of 4 consecutive quarters, the % of readmissions within 30 days of discharge does not exceed one standard deviation from the national mean as reported by NASMHPD



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.50	10.71	6.67	0.00	5.26	11.76	5.88	10.00	9.09	0.00	5.56	8.33	10.00	6.67	
Ntl Mean	5.17	5.57	5.19	5.07	5.68	5.59	5.34	5.38	5.30	4.70	5.28	5.46	4.67	4.78	
+1 StDev	11.98	12.39	11.46	10.74	12.57	12.32	12.90	11.95	11.32	10.02	11.60	12.83	10.10	10.60	

This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

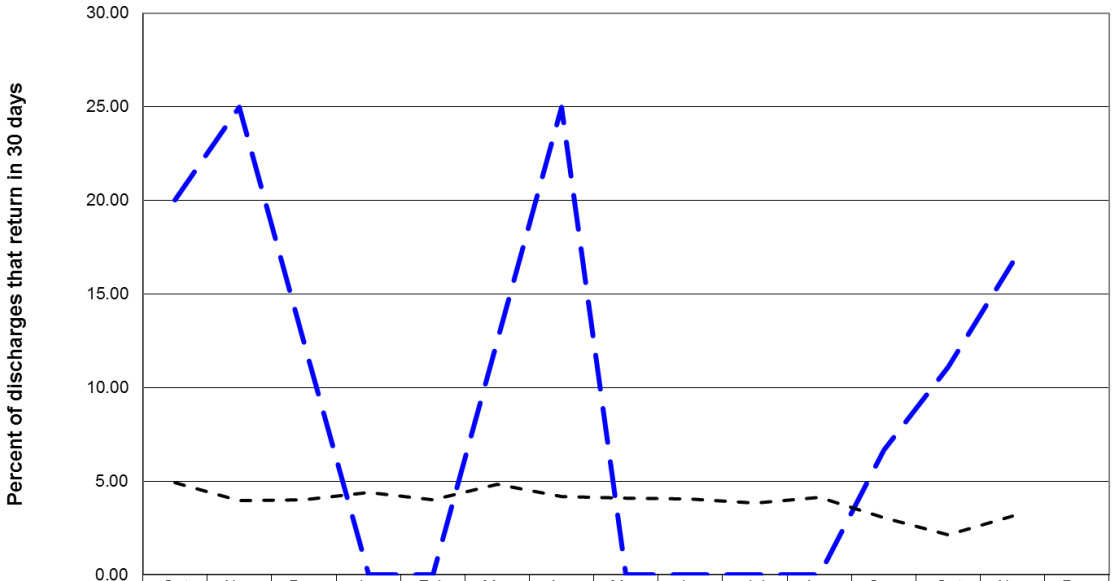
Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity to determine trends for causes of readmission. Between August 2013 and November 2014, the Lower Saco Unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record system whenever they transferred units within the hospital (either from or to Lower Saco), which caused them to show up as a 30 Day Readmission, even though they never left the hospital.

The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility stratified by forensic or civil classifications. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

CONSENT DECREE

30 Day Readmit

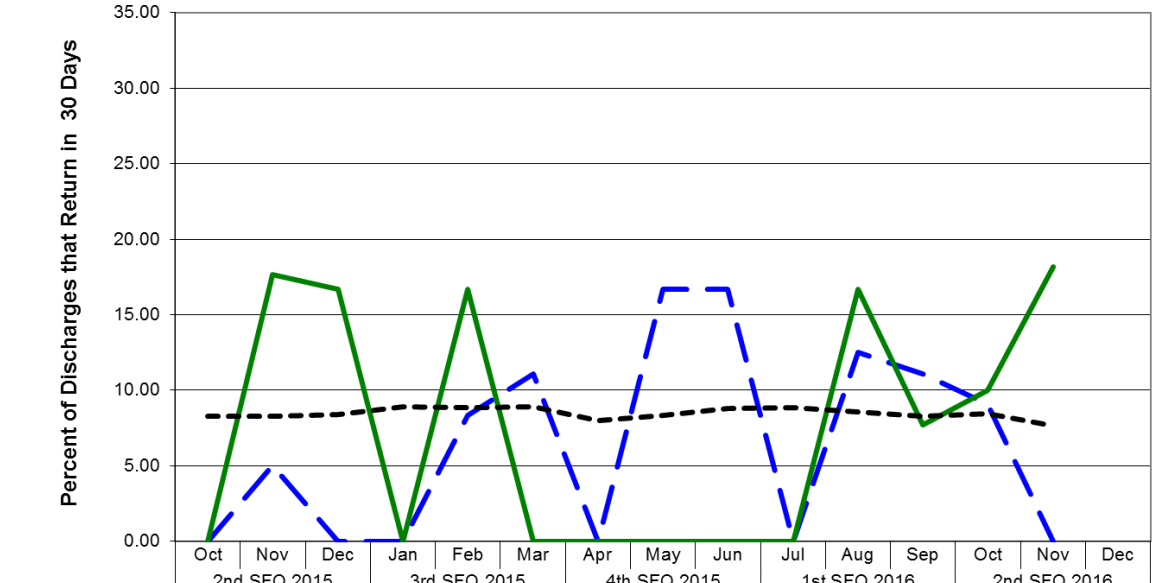
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	20.00	25.00	12.50	0.00	0.00	12.50	25.00	0.00	0.00	0.00	0.00	6.67	11.11	16.67	
Ntl Mean	4.93	3.98	4.02	4.41	3.99	4.84	4.19	4.11	4.04	3.84	4.14	3.06	2.12	3.15	

30 Day Readmit

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	5.00	0.00	0.00	8.33	11.11	0.00	16.67	16.67	0.00	12.50	11.11	9.09	0.00	
Dorothea Dix	0.00	17.65	16.67	0.00	16.67	0.00	0.00	0.00	0.00	0.00	16.67	7.69	10.00	18.18	
Ntl Mean	8.27	8.29	8.37	8.91	8.83	8.89	8.01	8.31	8.80	8.85	8.54	8.27	8.44	7.67	

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each patient who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge, and for each patient who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources; and, where such a need or change was indicated, that corrective action was taken.	100% 5/5	100% 2/2	100% 5/5	100% 4/4

2Q2016:

Four patients were readmitted in 2Q2016. Of the four readmitted, two spent less than 30 days in the community. Patient 1 spent 2 days in the community post discharge; he was readmitted after eloping while in the community. Patient 2 was discharged to Maine General for an emerging medical crisis for 4 days then was readmitted. Patient 3 was a forensic discharge from an IST evaluation and was readmitted on an NCR order 5 days after discharge. Patient 4 was a forensic discharge from a 60 day evaluation and returned within 23 days on an IST order.

CONSENT DECREE

Reduction of Re-Hospitalization for Outpatient Services Programs (OPS) Patients

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. The Program Service Director of the Outpatient Services Program will review all patient cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Patient demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 6/6	100% 1/1	100% 6/6	100% 2/2
2. Outpatient Services will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	100%

2Q2016:

1. Two patients returned to RPC: One patient due to an increase in delusional thought process who was experiencing difficulty with his vision causing a safety issue, and another patient for being intrusive, disruptive and oppositional.
2. 100% attendance at RPC treatment team meetings that OPS was scheduled to attend.

CONSENT DECREE

V7) Riverview certifies that no more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.

PATIENT ADMISSION DIAGNOSIS	3Q15	4Q15	1Q16	2Q16	TOTAL
ADJUSTMENT DISORDER WITH DEPRESSED MOOD				1	**1**
ADJUSTMENT DISORDER W/ MIXED DISTURBANCE OF EMOTIONS & CONDUCT		1	1		**2**
ADJUSTMENT REACTION NOS	1				**1**
ANTISOCIAL PERSONALITY			1		**1**
ATTENTION DEFICIT W/ HYPERACTIVITY			1		**1**
AUTISTIC DISORDER				1	**1**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD				1	**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES				1	**1**
BIPOLAR DISORDER, UNSPECIFIED	1		10	6	**17**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, SPEC W/ PSYCHOTIC BEHAV		1	1		**2**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, W/O PSYCHOTIC FEATURES		1	1		**2**
BIPOLAR I, MOST REC EPIS (OR CURRENT) MIXED, UNSPEC	1				**1**
BIPOLAR I, REC EPIS OR CURRENT MANIC, IN PARTIAL OR UNSPEC REMISSION		1	1		**2**
BIPOLAR I, REC EPIS OR CURRENT MANIC, SEVERE, W/ PSYCHOTIC BEHAV			2		**2**
DELUSIONAL DISORDERS		1	1	1	**3**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/O BEHAVRL DISTURB				1	**1**
DEPRESSIVE DISORDER NEC			3		**3**
DEPRESSIVE DISORDER-SEVERE	1	2			**3**
DEPRESSIVE DISORDER-UNSPEC			1		**1**
HEBEPHRENIA-UNSPEC	2				**2**
IMPULSE CONTROL DISORDER NOS		1			**1**
MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/O PSYCH FEATURES				1	**1**
OTH PSYCH DISORDER NOT DUE TO A SUB OR KNOWN PHYSIOL COND				1	**1**
OTHER SCHIZOPHRENIA				2	**2**

CONSENT DECREE

PATIENT ADMISSION DIAGNOSIS	3Q15	4Q15	1Q16	2Q16	TOTAL
OTHER SPEC PERVASIVE DEVELOPMENT DIS, CURRENT OR ACTIVE STATE	1	2			**3**
PARANOID SCHIZOPHRENIA				1	**1**
PARANOID SCHIZOPHRENIA-CHRONIC W/EXACERBATION	3				**3**
PARANOID SCHIZOPHRENIA-UNSPEC	1	1	1		**3**
POSTTRAUMATIC STRESS DISORDER	8	8	5	2	**23**
PSYCHOSIS NOS			4		**4**
RECURRENT DEPRESSIVE DISORDER-PSYCHOTIC		1	1		**2**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE				14	**14**
SCHIZOAFFECTIVE DISORDER, CHRONIC W/EXACER	17	17			**34**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED			14	6	**20**
SCHIZOPHRENIA NOS-CHRONIC	1	5			**6**
SCHIZOPHRENIA, UNSPECIFIED		1	14	9	**24**
UNSPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	6	2			**8**
UNSPECIFIED EPISODIC MOOD DISORDER			2		**2**
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSICAL COND				11	**11**
Total Admissions	43	45	64	59	**211**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0%	0%	0%	2%	**< 1%**

CONSENT DECREE

Peer Supports

Quarterly performance data shows that in 3 out of 4 consecutive quarters:

V8) 100% of all patients have documented contact with a peer specialist during hospitalization;

V9) 80% of all treatment meetings involve a peer specialist.

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Attendance at Comprehensive Treatment Team meetings. (v9)	96% 383/414	91% 383/414	89% 331/404 25 declined	86% 446/515
2. Attendance at Service Integration meetings. (v8)	93% 26/28	61% 19/31	97% 61/63	96% 47/49
3. Contact during admission. (v8)	100% 43/43	100% 45/45	100% 64/64	100% 49/49
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 71 163	100% 25 142	100% 58 27	100% 91 131
5. Peer Support will make an attempt to assist all patients in recognizing their personal medicine and filling out form.	100% 43/43	100% 45/45	0% 0/64	82% 40/49
6. Peer Support will make a documented attempt to have patients fill out a survey before discharge or annually to evaluate the effectiveness of the peer support relationship during hospitalization.	82% 46/56	62% 28/45	22% 14/63	41% 20/49
7. Grievances responded to on time by Peer Support, within 1 day of receipt.	100% 98/98	100% 86/86	100% 161/161	100% 97/97
8. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	New Indicator Added FY 2016		100% 64/64	100% 49/49
9. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	New Indicator Added FY 2016		100% 64/64	100% 49/49

CONSENT DECREE

2Q2016:

1. Out of the 515 treatment team meetings, Peer Support attended 404. For 45 meetings, the patient refused to have Peer Support at the meeting or Peer Support was not notified of the change in time of the meeting.

4. During this quarter, the Peer Support Coordinator will be implementing a new method to find candidates for the bridging program, which will be reported next quarter.

6. Due to staff turnover on one unit and orienting new staff surveys for one unit is lower than usual for the unit with the most discharges. This should be resolved in the next quarterly report. The Peer Support Coordinator will be going around monthly to each unit surveying the patients as to their view of the Peer Support Program and what stands in the way of giving data of completing surveys.

Treatment Planning

V10) 95% of patients have a preliminary treatment and transition plan developed within 3 working days of admission;

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
2. Patient participation in Service Integration Meeting.	93% 42/45	95% 43/45	93% 42/45	95% 43/45
3. Social Worker participation in Service Integration Meeting.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	95% 43/45	95% 43/45	97% 44/45	95% 43/45
5. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and Social Worker role.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
6. Annual Psychosocial Assessment completed and current in chart.	100% 10/10	100% 10/10	100% 10/10	100% 10/10

2Q2016:

2. Two patients declined to meet for the Service Integration Meeting and declined follow up.

4. Two Comprehensive Psychosocial Assessments were not completed within the 7 day timeframe.

CONSENT DECREE

V11) 95% of patients also have individualized treatment plans in their records within 7 days thereafter;

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	97% 44/45	100% 45/45	91% 41/45	95% 43/45
2. Treatment plans will have measurable goals and interventions listing patient strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 45/45	100% 45/45	100% 45/45	100% 45/45

2Q2016:

1. Two charts had a late progress note for the prior week which was found during chart audits. The meeting was held with patient but the note was a late entry. This issue was discussed with the individual team members and support was given in supervision.

V12) Riverview certifies that all treatment modalities required by ¶155 are available.

The treatment modalities listed below as listed in ¶155 are offered to all patients according to the individual patient's ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the patient during the formulation of the individualized treatment plan.

Treatment Modality	Provision of Services Normally by….			
	Medical Staff Psychology	**Nursing**	**Social Services**	**Rehabilitation Services/ Treatment Mall**
Group and Individual Psychotherapy	X			
Psychopharmacological Therapy	X			
Social Services			X	
Physical Therapy				X
Occupational Therapy				X
ADL Skills Training		X		X
Recreational Therapy				X
Vocational/Educational Programs				X
Family Support Services and Education		X	X	X
Substance Abuse Services	X			
Sexual/Physical Abuse Counseling	X			
Introduction to Basic Principles of Health, Hygiene, and Nutrition		X		X

CONSENT DECREE

An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V13) The treatment plans reflect:

- Screening of the patient's needs in all the domains listed in ¶61;
- Consideration of the patient's need for the services listed in ¶155;
- Treatment goals for each area of need identified, unless the patient chooses not, or is not yet ready, to address that treatment goal;
- Appropriate interventions to address treatment goals;
- Provision of services listed in ¶155 for which the patient has an assessed need;
- Treatment goals necessary to meet discharge criteria; and
- Assessments of whether the patient is clinically safe for discharge;

V14) The treatment provided is consistent with the individual treatment plans;

V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

An abstraction of pertinent elements of a random selection of charts is periodically conducted to determine compliance with the compliance standards of the consent decree outlined in parts V13, V14, and V15.

This review of randomly selected charts revealed substantial compliance with the consent decree elements. Individual charts can be reviewed by authorized individuals to validate this chart review.

Medications

V16) Riverview certifies that the pharmacy computer database system for monitoring the use of psychoactive medications is in place and in use, and that the system as used meets the objectives of ¶168.

Riverview utilizes a Pyxis Medstation 4000 System for the dispensing of medications on each patient care unit. A total of six devices, one on each of the four main units and in each of the two special care units, provide access to all medications used for patient care, the pharmacy medication record, and allow review of dispensing and administration of pharmaceuticals.

A database program, HCS Medics, contains records of medication use for each patient and allows access by an after-hours remote pharmacy service to these records, to the Pyxis Medstation 4000 System. The purpose of this after-hours service is to maintain 24 hour coverage and pharmacy validation and verification services for prescribers.

Records of transactions are evaluated by the Director of Pharmacy and the Clinical Director to validate the appropriate utilization of all medication classes dispensed by the hospital. The Pharmacy and Therapeutics Committee, a multidisciplinary group of physicians, pharmacists, and other clinical staff, evaluate issues related to the prescribing, dispensing, and administration of all pharmaceuticals.

The system as described is capable of providing information to process reviewers on the status of medications management in the hospital and to ensure the appropriate use of psychoactive and other medications.

The effectiveness and accuracy of the Pyxis Medstation 4000 System is analyzed regularly through the conduct of process improvement and functional efficiency studies. These studies can be found in the Medication Management and Pharmacy Services sections of this report.

CONSENT DECREE

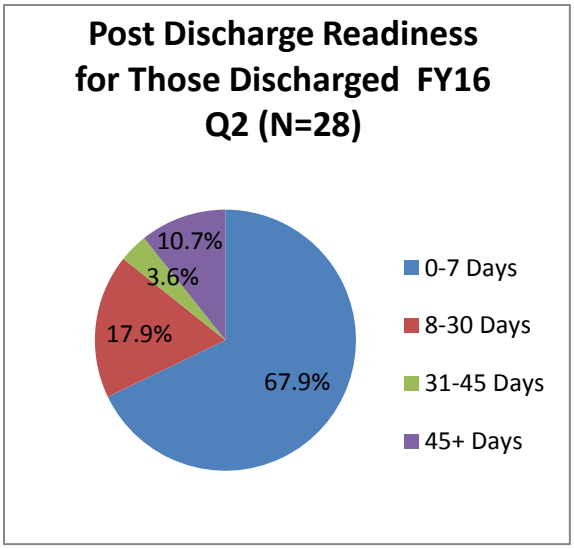
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

V17) 70% of patients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care;

V18) 80% of patients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care;

V19) 90% of patients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain patients excepted, by agreement of the parties and Court Master).



Cumulative percentages & targets are as follows:

Within 7 days = (19) 67.9% (target 70%)

Within 30 days = (5) 85.7% (target 80%)

Within 45 days = (1) 89.3% (target 90%)

Post 45 days = (3) 10.7% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Residential Supports (0) No barriers in this area	Housing (9) • 5 patients discharged 8-30 days post clinical readiness (9, 10(2), 15, and 20 days) • 1 patient discharged 31-45 days post clinical readiness (33 days) • 3 patients discharged 45+ days post clinical readiness (49, 63 and 79 days)
Treatment Services (0) No barriers in this area	
Other (0) No barriers in this area	

CONSENT DECREE

The previous four quarters are displayed in the table below

		Within 7 days	Within 30 days	Within 45 days	45+ days
Target >>		**70%**	**80%**	**90%**	**< 10%**
1Q2016	N=34	64.7%	82.3%	91.1%	8.9%
4Q2015	N=29	65.6%	86.2%	93.1%	6.9%
3Q2015	N=38	78.9%	86.8%	89.4%	10.6%
2Q2015	N=39	82.1%	87.2%	89.7%	10.3%

CONSENT DECREE

An evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V20) Treatment and discharge plans reflect interventions appropriate to address discharge and transition goals;

V20a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

V21) Interventions to address discharge and transition planning goals are in fact being implemented;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 10/10	100% 12/12	100% 12/12	100% 12/12
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 10/10	100% 12/12	100% 12/12	100% 12/12
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	90% 9/10	92% 11/12	83% 10/12	92% 11/12
4. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 10/10	100% 12/12	100% 12/12	92% 11/12

2Q2016:

3. On one occasion the report was not sent out electronically during the week, it was presented at the Wednesday Housing Meeting as a two week snapshot, due to the Director's vacation.

CONSENT DECREE

V22) The Department demonstrates that 95% of the annual reports for forensic patients are submitted to the Commissioner and forwarded to the court on time.

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	0% 0/8	66% 2/3	66% 2/3	0% 0/6
2. The assigned **CCM** will review the new court order with the patient and document the meeting in a progress note or treatment team note.	100% 2/2	100% 3/3	100% 3/3	100% 3/3
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	N/A	N/A	0% 0/25

2Q2016:

1. Six Institutional Reports were completed, but none of the reports were completed in the 10 business day timeframe. We continue to monitor the process to track the reports in the quarter to get improved results for completion.
2. None of the NCR annual reports were completed in December. They remain in process and will be completed and reported on in 3Q2016.

Staffing and Staff Training

V23) Riverview performance data shows that 95% of direct care staff have received 90% of their annual training.

Indicators	3Q2015	4Q2015	1Q2016	2Q2016	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 26/26	98% 55/56	100% 55/55	100% 47/47	**99% 183/184**
2. Riverview and Contract staff will attend Annual training.	74% 34/46	89% 25/28	86% 89/104	97% 56/58	**86% 204/236**
3. Riverview and contract staff will attend MOAB training bi-annually	99% 389/391	94% 421/446	100% 28/28	100% 11/11	**97% 849/876**

2Q2016:

2. Two employees are out of compliance for the month of December. Employees and their supervisors have been notified and corrective action is being taken. All staff out of compliance in 1Q2016 are now in compliance.

3. MOAB was initiated in January 2014. This quarter a total of 11 employees received MOAB training. Since the initiation date 351 current employees have completed MOAB training. Recertification trainings will begin January 2016. Data will be collected to reflect new employees who have been trained in MOAB as well as those who have been recertified. Beginning 3Q2016, RPC staff (including contractors) will attend MOAB annually. This is a leadership initiative to improve staff competence and confidence when working with physically aggressive patients to safely and effectively manage behavior through the use of verbal de-escalation and physical intervention strategies.

CONSENT DECREE

Responsible Party: Susan Bundy, Director of Staff Development

I. Measure Name: Ongoing Education and Training

Measure Description: HR.01.05.03 requires that staff will participate in ongoing education and training to increase and maintain their competency.

Type of Measure: Performance Improvement

Goal: 90% of direct support staff will attend Non Violent Communication and Motivational Interviewing training by June 2016. Attendance will be tracked by Staffing and Organizational Development. Progress will be reported quarterly.

Progress: To date, 216 out of 375 current employees have attended Non-Violent Communication (NVC) Training. 85 have attended eight hour NVC Training. 111 employees have attended Motivational Interviewing training to date.

Comments: Neither Non-Violent Communication or Motivational Interviewing was offered in 1Q2016 or 2Q2016 due to staff shortages and budgetary constraints. RPC remains committed to this goal. Motivational Interviewing is scheduled for January 2016.

II. Measure Name: Seclusion and Restraint Reduction

Measure Description: Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate restraint and seclusion through effective performance improvement initiatives.

Type of Measure: Performance Improvement

Goal: RPC will decrease the use of seclusion and restraint by 50%.

FY 2015	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	99	10	105	**214**
Quarter 2	107	16	97	**220**
Quarter 3	61	1	62	**124**
Quarter 4	94	4	92	**190**
Total # of events	**361**	**31**	**356**	**748**

***Average # of events per month in FY 2015: 62.3**

CONSENT DECREE

FY 2016	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	95	6	75	**176**
Quarter 2	61	0	43	**104**
Quarter 3				
Quarter 4				
Total # of events	**156**	**6**	**118**	**280**

***Average # of events per month in FY 2016 to date: 47**

Action Plan:

Staff will receive initial and ongoing education training in MOAB, Non Violent Communication and Motivational Interviewing to assist in establishing therapeutic relationships so that, when a crisis begins, staff will be more influential and effective in preventing the use of seclusion and restraint. Staff Development will provide ongoing education to reinforce the organization's commitment to ensuring a caring, respectful, therapeutic environment. Data gathered through hospital performance measures will be analyzed to determine progress.

CONSENT DECREE

V24) Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216;

DATE	HRS	TITLE	PRESENTER
3Q2015	13	January – March 2015	
4Q2015	17	April – June 2015	
1Q2016	4	July – September 2015	
10/1/2015	1	Shared Decision-Making in the Care of Adults with Severe Mental Illnesses	Will Torrey, MD
10/5/2015	6	Assessment of Risk for Violence in Juveniles	Debra Baeder, PhD, ABPP
10/8/2015	1	A Selection of Medical Co-morbidities in Patients Admitted Over the Past Year	George Davis, MD
10/15/2015	1	Under the Surface: Exploring attachment patterns, family roles and personality traits	Brooke Hoffmann
10/22/2015	1	Pharmacologic Treatment for Alcohol & Opiate Use Disorders: A review of current evidence	Sarah Perry, PharmD
10/29/2015	2	Diagnosis Over a Time Period: A Patient Review with Dartmouth	Miriam Davidson, PMHNP Dan Filene, MD Art Dirocco, PhD Lorraine Zamudio, PsyD
11/12/2015	1	Practical Guide for the Treatment of Nightmares	Randall Beal, PMNP
11/17/2015	1	Med Staff PI & QA Committee	Brendan Kirby, MD
11/19/2015	1	Back when the Barn was New: Part II	Susan Newkirk-Sanborn, PhD
12/3/2015	1	Management of Insomnia	Sarah Perry, PharmD Alexii West, PharmD Student
12/10/2015	1	Facing the End of Life in a Psychiatric Hospital	Regana Sisson, MD
12/16/2015	1	Public Guardianship Training	David White/Jeff Shapiro, OADS
12/17/2015	1	Dancing with the Devil: A Review of Old and New Street Drugs	David Dettmann, DO

V25) Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month;

Staff Type	Consent Decree Ratio
General Medicine Physicians	1:75
Psychiatrists	1:25
Psychologists	1:25
Nursing	1:20
Social Workers	1:15
Mental Health Workers	1:6
Recreational/Occupational Therapists/Aides	1:8

With 92 beds, Riverview regularly meets or exceeds the staffing ratio requirements of the consent decree.

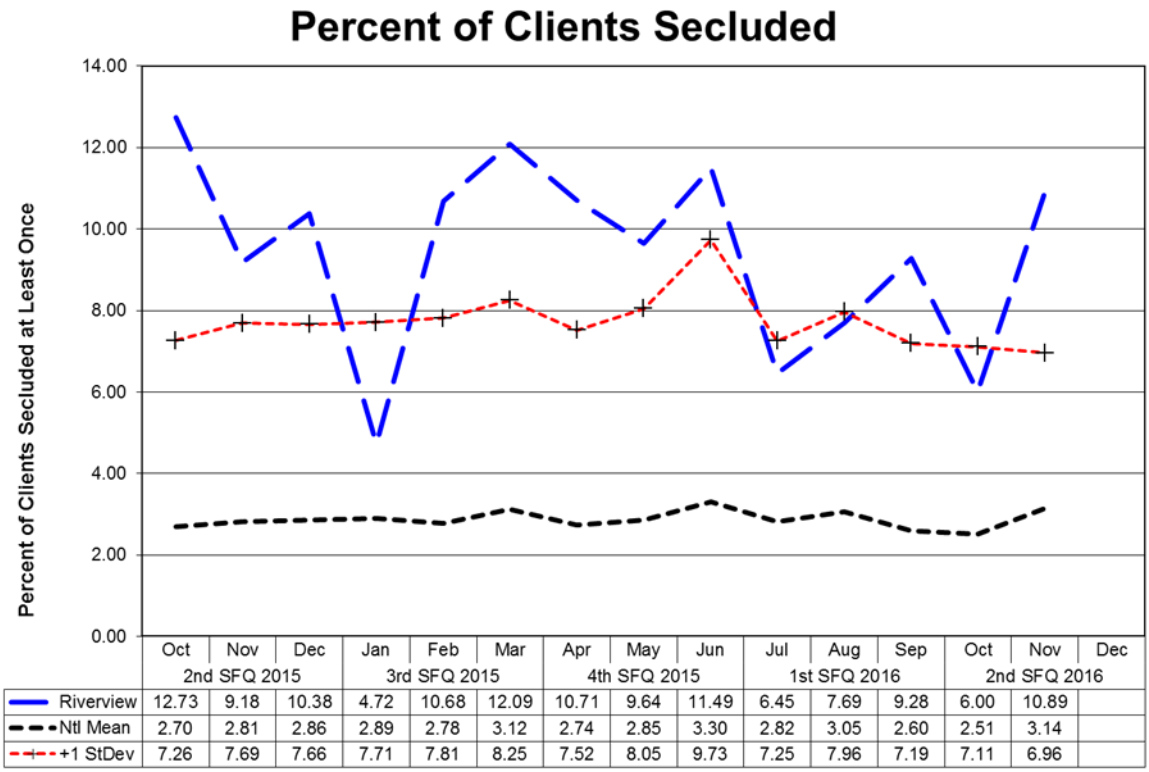
Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the patients who reside on specific units, and unit census.

V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.

Treatment teams regularly monitor the needs of individual patients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment of patient needs. Staffing deficiencies that may periodically be present are rectified through utilization of overtime or mandated staff members.

Use of Seclusion and Restraints

V27) Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD;



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.73	9.18	10.38	4.72	10.68	12.09	10.71	9.64	11.49	6.45	7.69	9.28	6.00	10.89	
Ntl Mean	2.70	2.81	2.86	2.89	2.78	3.12	2.74	2.85	3.30	2.82	3.05	2.60	2.51	3.14	
+1 StDev	7.26	7.69	7.66	7.71	7.81	8.25	7.52	8.05	9.73	7.25	7.96	7.19	7.11	6.96	

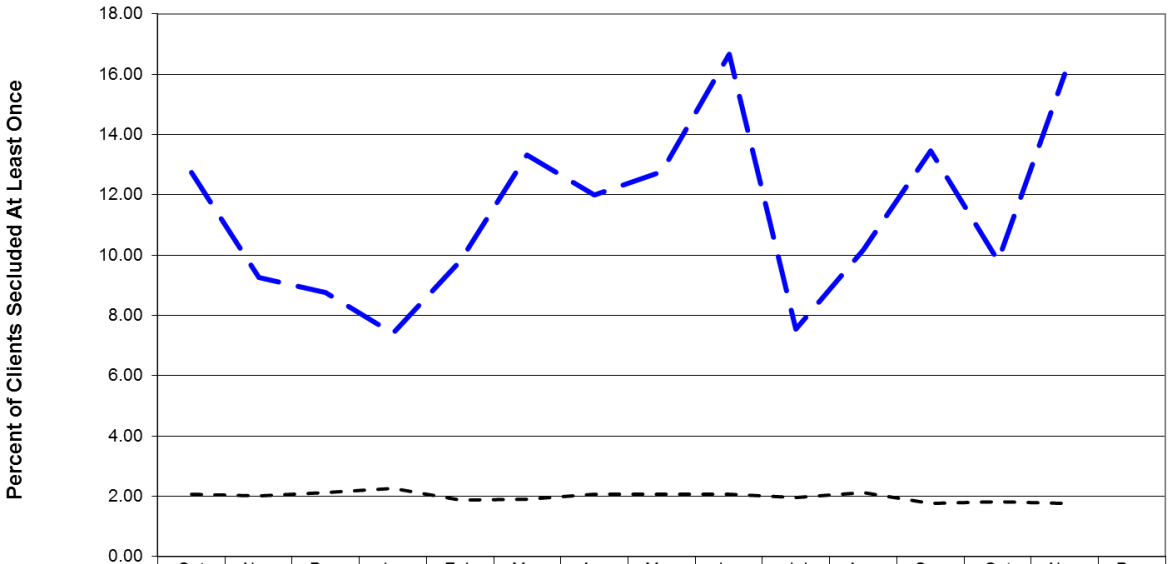
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

The following graphs depict the percent of unique patients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique patients served were secluded at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Secluded

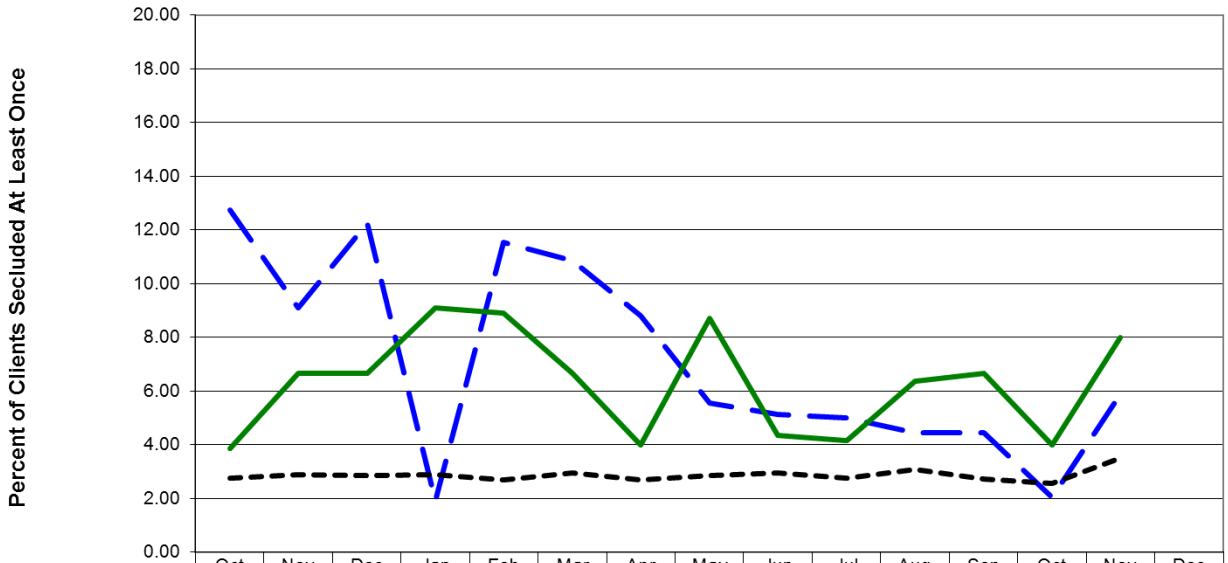
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.73	9.26	8.77	7.41	9.80	13.33	12.00	12.77	16.67	7.55	10.17	13.46	9.80	16.00	
Ntl Mean	2.08	2.02	2.11	2.25	1.86	1.89	2.08	2.08	2.08	1.95	2.11	1.76	1.83	1.75	

Percent of Clients Secluded

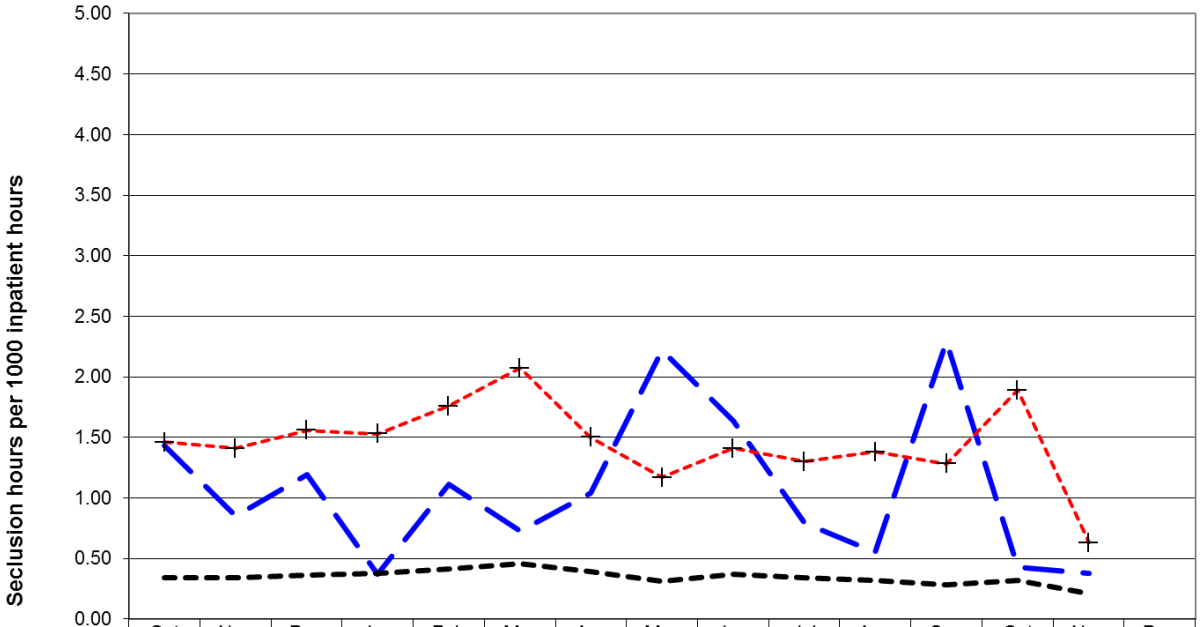
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.73	9.09	12.24	1.92	11.54	10.87	8.82	5.56	5.13	5.00	4.44	4.44	2.04	5.88	
Dorothea Dix	3.85	6.67	6.67	9.09	8.89	6.67	4.00	8.70	4.35	4.17	6.38	6.67	4.00	8.00	
Ntl Mean	2.75	2.90	2.85	2.89	2.71	2.95	2.69	2.86	2.97	2.77	3.08	2.73	2.58	3.51	

CONSENT DECREE

Seclusion Hours



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	1.43	0.85	1.19	0.37	1.11	0.73	1.04	2.22	1.64	0.79	0.55	2.29	0.43	0.38	
Ntl Mean	0.34	0.34	0.36	0.38	0.41	0.46	0.39	0.31	0.37	0.34	0.32	0.28	0.32	0.21	
+1 StDev	1.46	1.41	1.56	1.53	1.76	2.07	1.50	1.17	1.41	1.30	1.38	1.28	1.89	0.63	

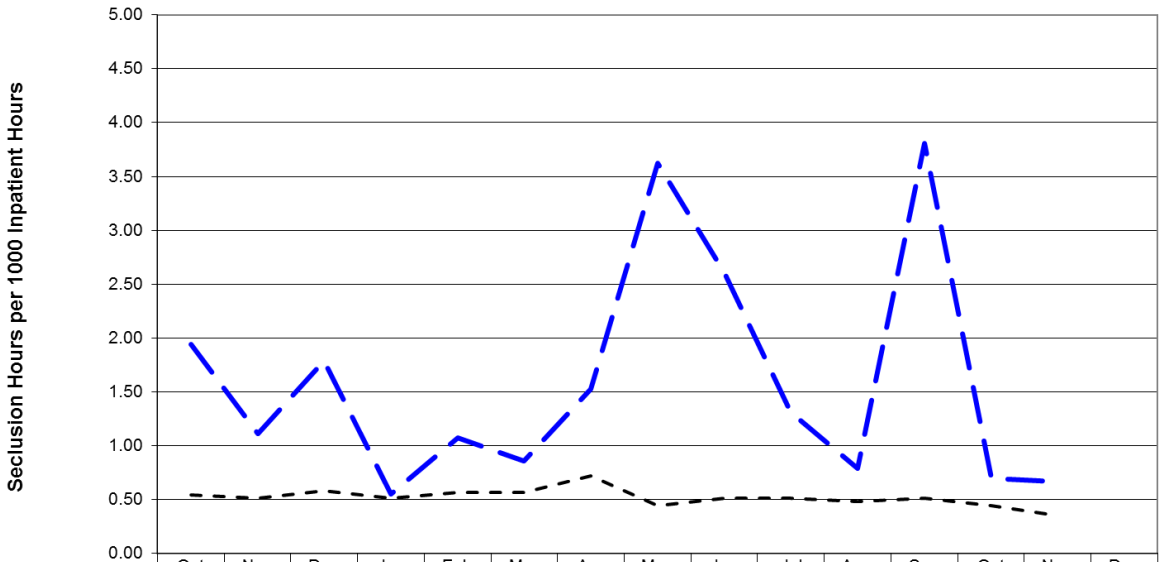
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

The following graphs depict the number of hours patients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Seclusion Hours

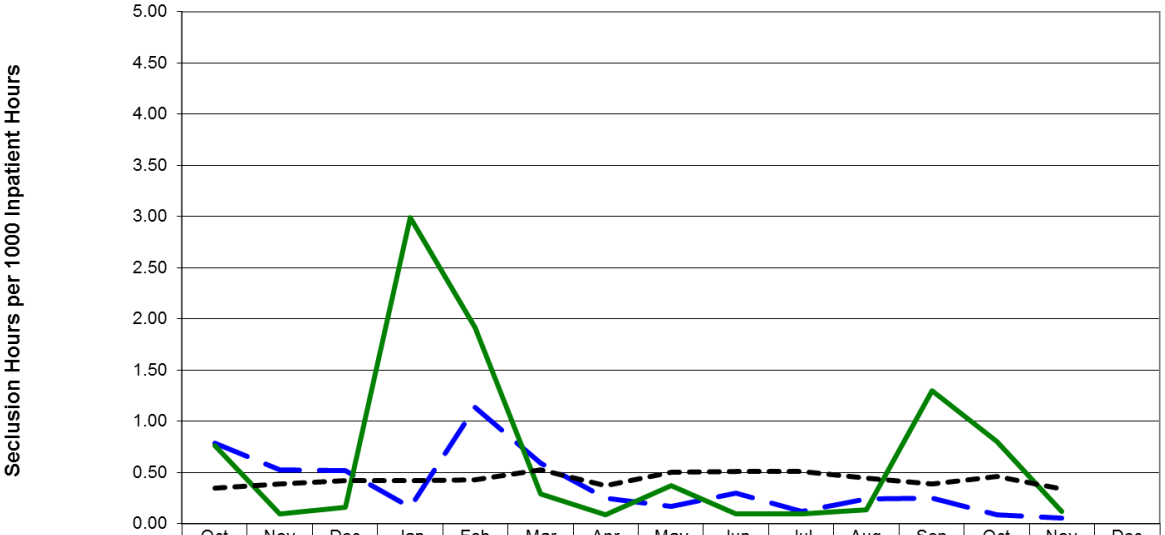
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	1.94	1.11	1.79	0.55	1.07	0.86	1.53	3.62	2.60	1.31	0.79	3.81	0.70	0.67	
Ntl Mean	0.54	0.51	0.58	0.51	0.57	0.57	0.72	0.44	0.51	0.51	0.48	0.51	0.44	0.35	

Seclusion Hours

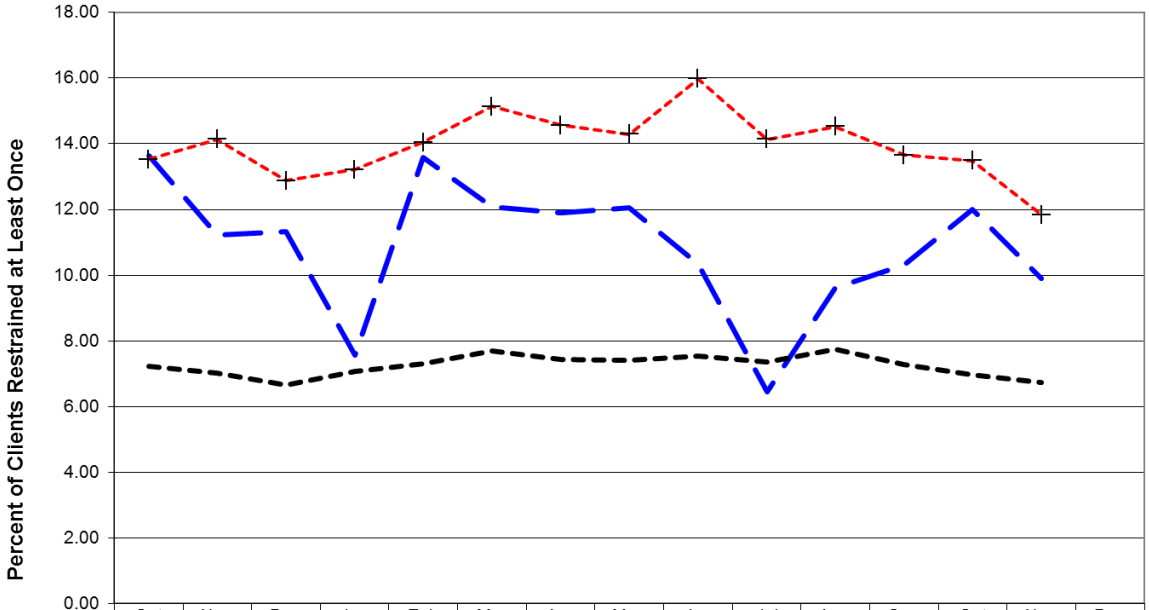
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.79	0.53	0.52	0.16	1.14	0.59	0.25	0.17	0.30	0.12	0.24	0.25	0.09	0.06	
Dorothea Dix	0.76	0.10	0.16	2.99	1.92	0.29	0.09	0.37	0.10	0.10	0.14	1.30	0.80	0.12	
Ntl Mean	0.35	0.39	0.42	0.42	0.43	0.53	0.37	0.50	0.51	0.51	0.45	0.39	0.46	0.34	

CONSENT DECREE

Percent of Clients Restrained



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	13.64	11.22	11.32	7.55	13.59	12.09	11.90	12.05	10.34	6.45	9.62	10.31	12.00	9.90	
Ntl Mean	7.23	7.01	6.66	7.07	7.29	7.69	7.42	7.41	7.54	7.35	7.74	7.28	6.96	6.73	
+1 StDev	13.52	14.13	12.88	13.22	14.05	15.14	14.57	14.29	15.98	14.14	14.53	13.66	13.49	11.84	

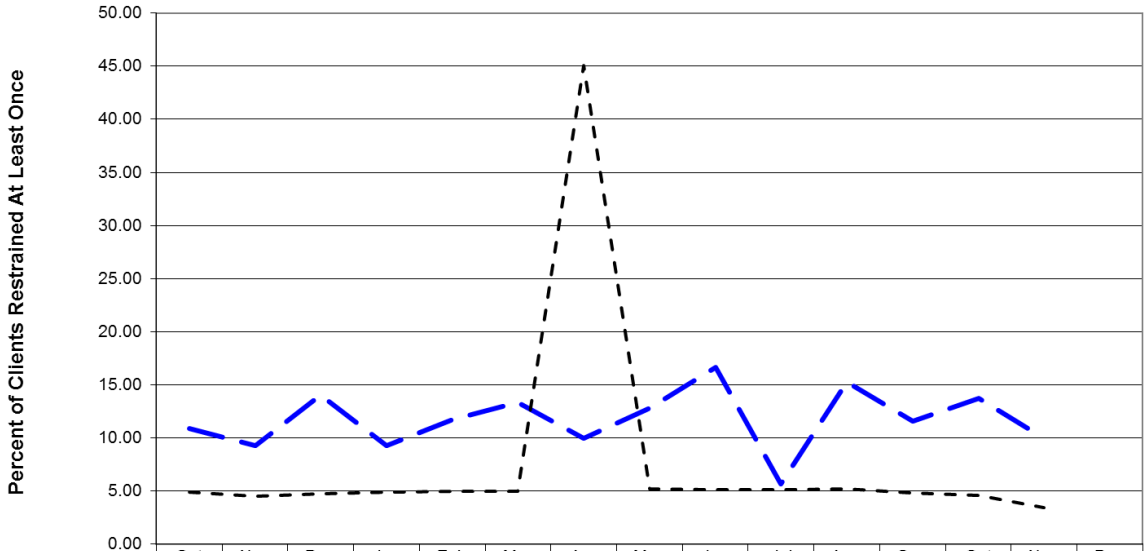
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

The following graphs depict the percent of unique patients who were restrained at least once stratified by forensic or civil classifications, and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Restrained

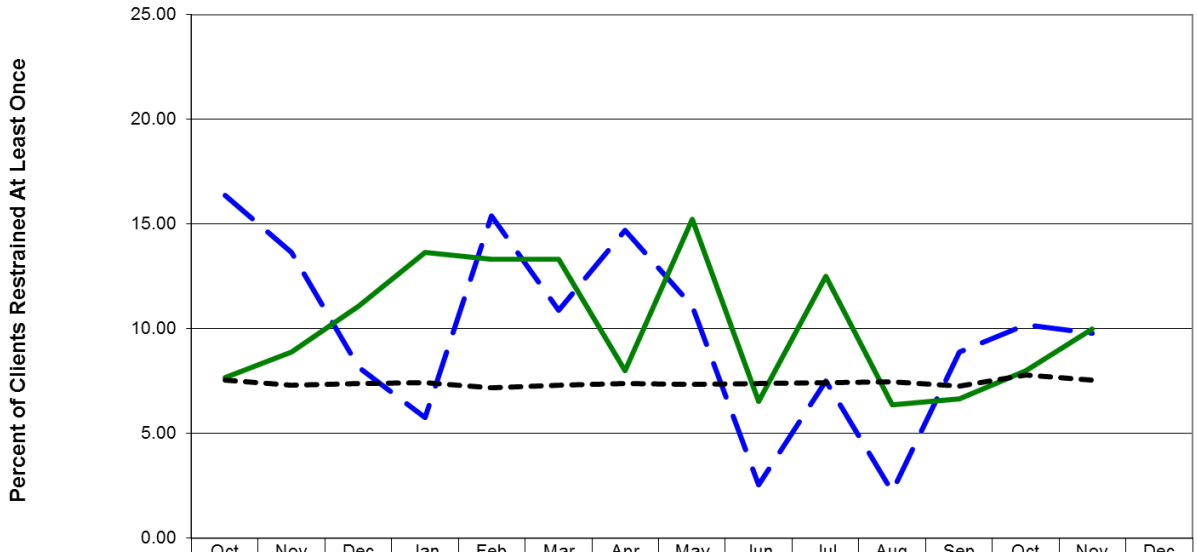
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	10.91	9.26	14.04	9.26	11.76	13.33	10.00	12.77	16.67	5.66	15.25	11.54	13.73	10.00	
Ntl Mean	4.89	4.52	4.71	4.87	4.95	4.96	45.07	5.19	5.14	5.15	5.20	4.78	4.56	3.44	

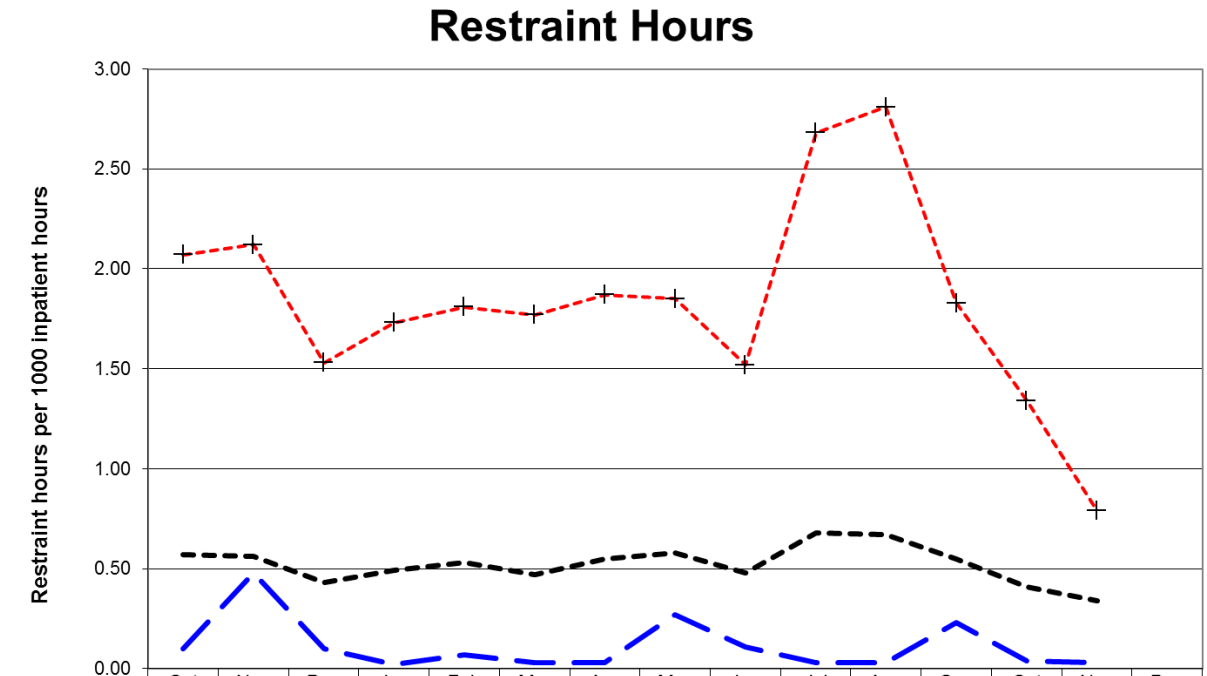
Percent of Clients Restrained

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	16.36	13.64	8.16	5.77	15.38	10.87	14.71	11.11	2.56	7.50	2.22	8.89	10.20	9.80	
Dorothea Dix	7.69	8.89	11.11	13.64	13.33	13.33	8.00	15.22	6.52	12.50	6.38	6.67	8.00	10.00	
Ntl Mean	7.56	7.31	7.38	7.43	7.20	7.33	7.40	7.35	7.41	7.44	7.47	7.28	7.80	7.55	

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.10	0.48	0.10	0.02	0.07	0.03	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	
Ntl Mean	0.57	0.56	0.43	0.49	0.53	0.47	0.55	0.58	0.48	0.68	0.67	0.55	0.41	0.34	
+1 StDev	2.07	2.12	1.53	1.73	1.81	1.77	1.87	1.85	1.52	2.68	2.81	1.83	1.34	0.79	

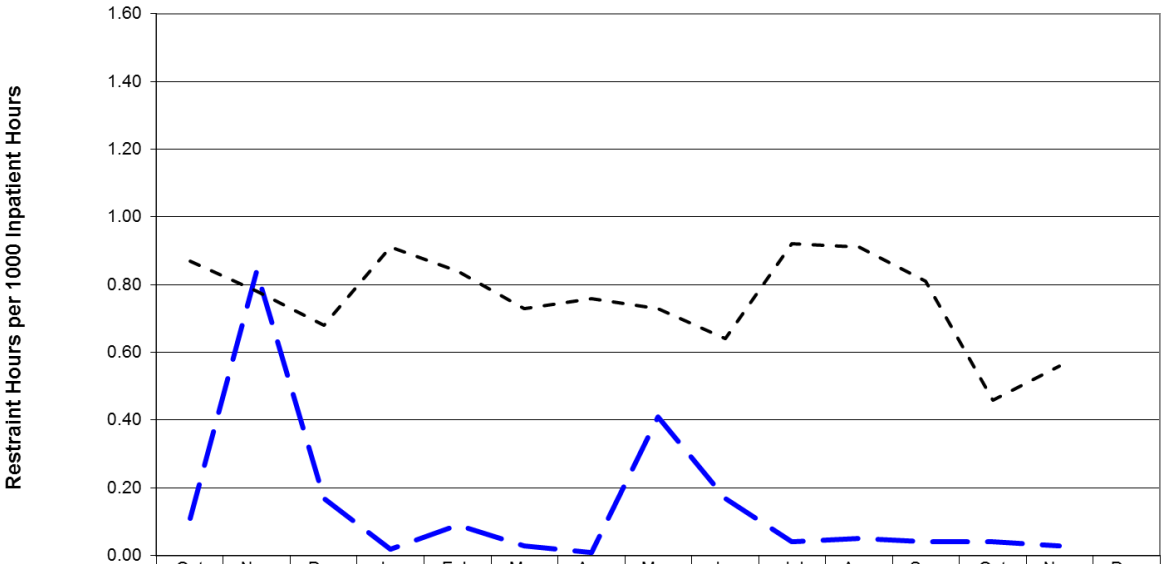
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

The following graphs depict the number of hours patients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Restraint Hours

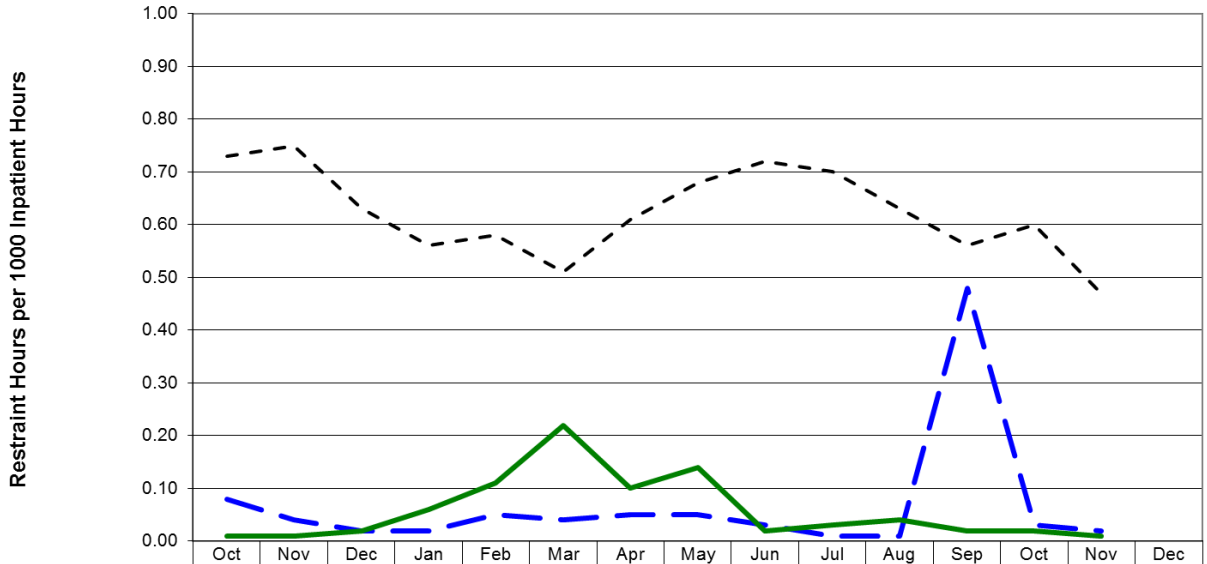
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.11	0.84	0.17	0.02	0.09	0.03	0.01	0.41	0.17	0.04	0.05	0.04	0.04	0.03	
Ntl Mean	0.87	0.78	0.68	0.91	0.84	0.73	0.76	0.73	0.64	0.92	0.91	0.81	0.46	0.56	

Restraint Hours

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.08	0.04	0.02	0.02	0.05	0.04	0.05	0.05	0.03	0.01	0.01	0.48	0.03	0.02	
Dorothea Dix	0.01	0.01	0.02	0.06	0.11	0.22	0.10	0.14	0.02	0.03	0.04	0.02	0.02	0.01	
Ntl Mean	0.73	0.75	0.63	0.56	0.58	0.51	0.61	0.68	0.72	0.70	0.63	0.56	0.60	0.47	

CONSENT DECREE

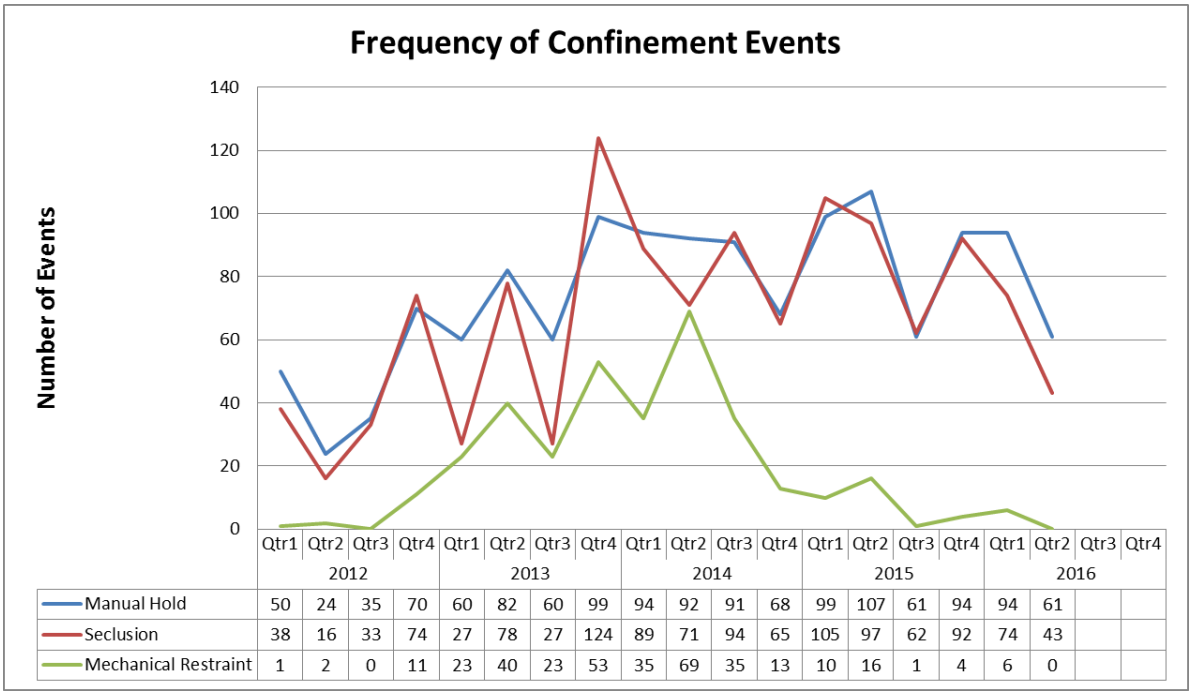
Confinement Event Detail

2Q2016

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR3374	16		11	27	25.96%	25.96%
MR193	7		6	13	12.50%	38.46%
MR7833	6		4	10	9.62%	48.08%
MR104	3		3	6	5.77%	53.85%
MR7127	3		2	5	4.81%	58.65%
MR7809	1		4	5	4.81%	63.46%
MR7032	1		3	4	3.85%	67.31%
MR7607	2		2	4	3.85%	71.15%
MR107	1		2	3	2.88%	74.04%
MR763	3			3	2.88%	76.92%
MR4841	1		1	2	1.92%	78.85%
MR5267	1		1	2	1.92%	80.77%
MR7118	2			2	1.92%	82.69%
MR7495	2			2	1.92%	84.62%
MR7575	1		1	2	1.92%	86.54%
MR7820	1		1	2	1.92%	88.46%
MR7823	2			2	1.92%	90.38%
MR7846	1		1	2	1.92%	92.31%
MR4	1			1	0.96%	93.27%
MR7189	1			1	0.96%	94.23%
MR7509	1			1	0.96%	95.19%
MR7739	1			1	0.96%	96.15%
MR7828	1			1	0.96%	97.12%
MR7830	1			1	0.96%	98.08%
MR7837	1			1	0.96%	99.04%
MR1187			1	1	0.96%	100.00%
	61	**0**	**43**	**104**		

31% (26/85) of the average hospital population experienced some form of confinement event during 2Q2016. Five of these patients (6% of the average hospital population) accounted for 58.65% of the containment events.

CONSENT DECREE



	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
	2012				2013				2014				2015				2016			
Manual Hold	50	24	35	70	60	82	60	99	94	92	91	68	99	107	61	94	94	61		
Seclusion	38	16	33	74	27	78	27	124	89	71	94	65	105	97	62	92	74	43		
Mechanical Restraint	1	2	0	11	23	40	23	53	35	69	35	13	10	16	1	4	6	0		

V28) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior;

Factors of Causation Related to Seclusion Events

	3Q2015	4Q2015	1Q2016	2Q2016	Total
Danger to Others/Self	7	88	74	43	**212**
Danger to Others	55	1			**56**
Danger to Self		3			**3**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**62**	**92**	**74**	**43**	**271**

V29) Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others;

Factors of Causation Related to Mechanical Restraint Events

	3Q2015	4Q2015	1Q2016	2Q2016	Total
Danger to Others/Self		4	6		**10**
Danger to Others	1				**1**
Danger to Self					**0**
% Dangerous Precipitation	100%	100%	100%		**100%**
Total Events	**1**	**4**	**6**	**0**	**11**

V30) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2.**

See Pages 30 & 31

CONSENT DECREE

Confinement Events Management

Seclusion Events (43) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%

CONSENT DECREE

Confinement Events Management

Seclusion Events, Continued (43) Events

Standard	Threshold	Compliance
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to Clinical Director and Patient Advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (0) Events

Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	N/A
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	N/A
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	N/A
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	N/A
The record reflects that, if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	N/A
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	N/A
The record reflects that the patient was kept under constant observation during restraint.	95%	N/A
Individuals implementing restraint have been trained in techniques and alternatives.	90%	N/A
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	N/A
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	N/A
The medical order shall state the conditions under which the patient may be sooner released.	85%	N/A

CONSENT DECREE

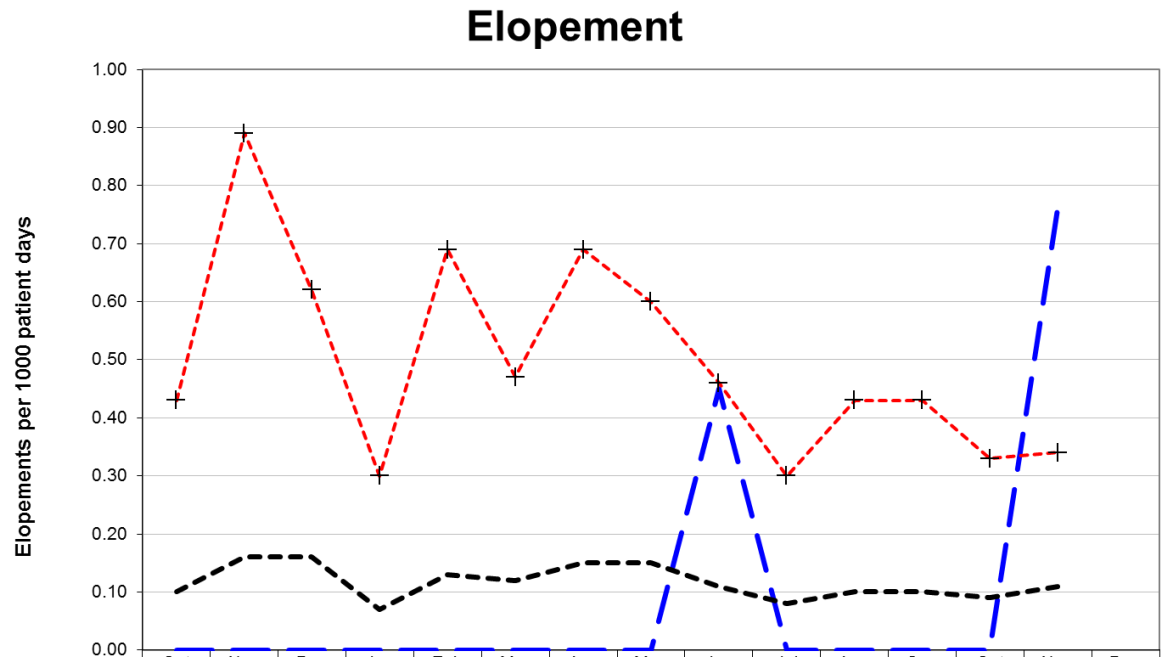
Confinement Events Management

Mechanical Restraint Events, Continued (0) Events

Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	N/A
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	N/A
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	N/A
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	N/A
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	N/A
Copies of events were forwarded to Clinical Director and Patient Advocate.	90%	N/A
For persons with mental retardation, the applicable regulations were met.	85%	N/A
The record reflects that the order was not entered as a PRN order.	90%	N/A
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Clinical Director (or if the Clinical Director is out of the hospital, by the individual acting in the Clinical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	N/A

Patient Elopements

V31) Quarterly performance data shows that, in 5 out of 6 quarters, the number of patient elopements does not exceed one standard deviation from the national mean as reported by NASMHPD.



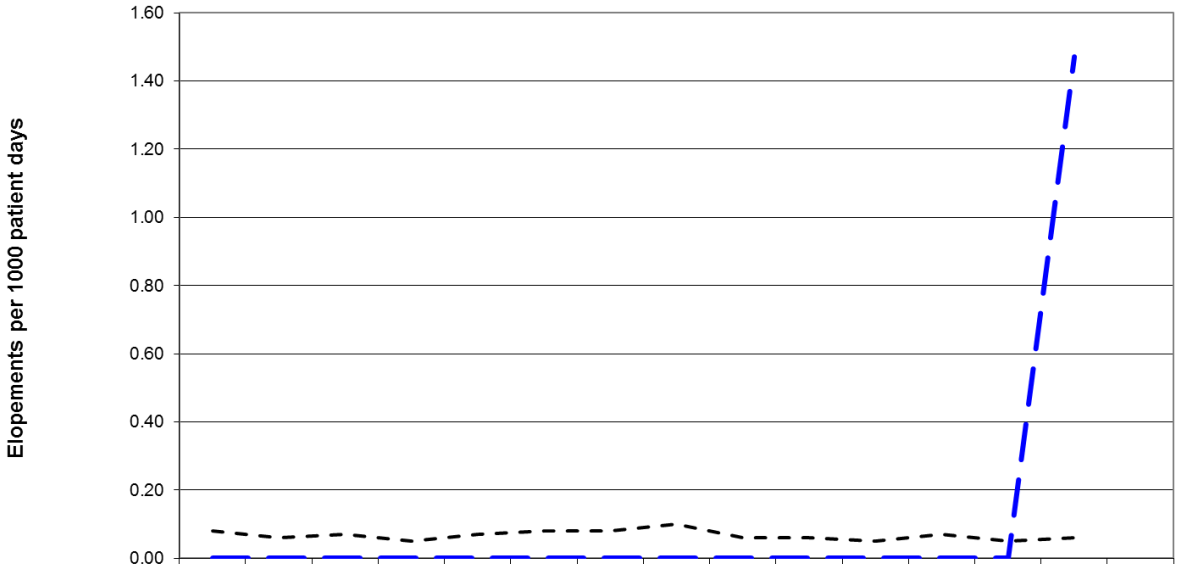
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.45	0.00	0.00	0.00	0.00	0.76	
Ntl Mean	0.10	0.16	0.16	0.07	0.13	0.12	0.15	0.15	0.11	0.08	0.10	0.10	0.09	0.11	
+1 StDev	0.43	0.89	0.62	0.30	0.69	0.47	0.69	0.60	0.46	0.30	0.43	0.43	0.33	0.34	

This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.
An elopement is defined as any time a patient is "absent from a location defined by the patient's privilege status regardless of the patient's leave or legal status."

The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

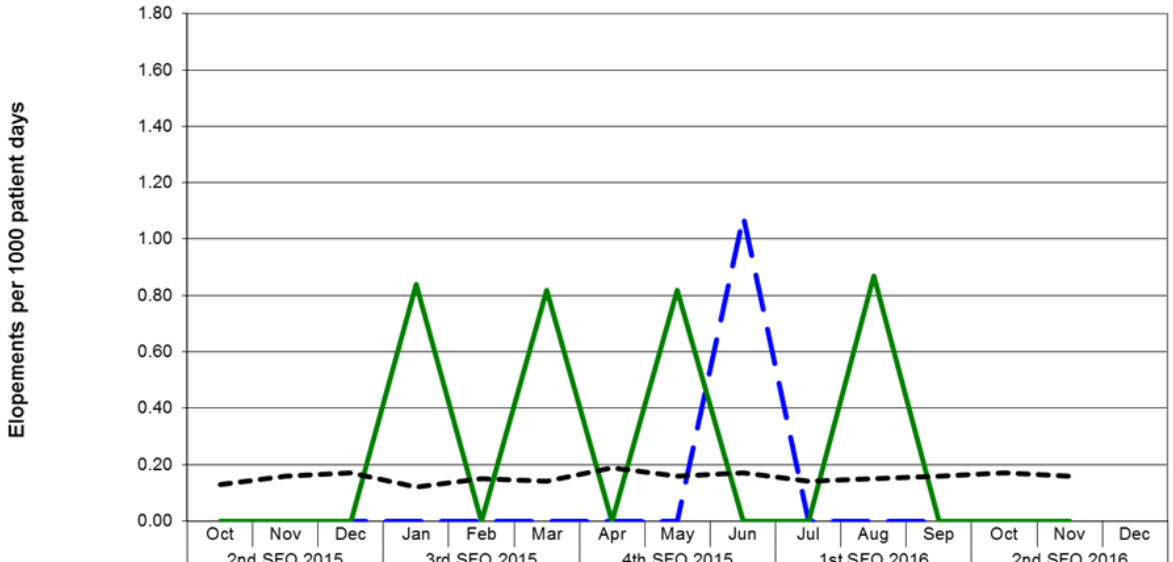
CONSENT DECREE

Elopement
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.47	
Ntl Mean	0.08	0.06	0.07	0.05	0.07	0.08	0.08	0.10	0.06	0.06	0.05	0.07	0.05	0.06	

Elopement
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.08	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.84	0.00	0.82	0.00	0.82	0.00	0.00	0.87	0.00	0.00	0.00	
Ntl Mean	0.13	0.16	0.17	0.12	0.15	0.14	0.19	0.16	0.17	0.14	0.15	0.16	0.17	0.16	

Patient Injuries

V32) Quarterly performance data shows that, in 5 out of 6 quarters, the number of patient injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.

The NASMHPD standards for measuring patient injuries differentiate between injuries that are considered reportable to the Joint Commission as a performance measure and those injuries that are of a less severe nature. While all injuries are currently reported internally, only certain types of injuries are documented and reported to NRI for inclusion in the performance measure analysis process.

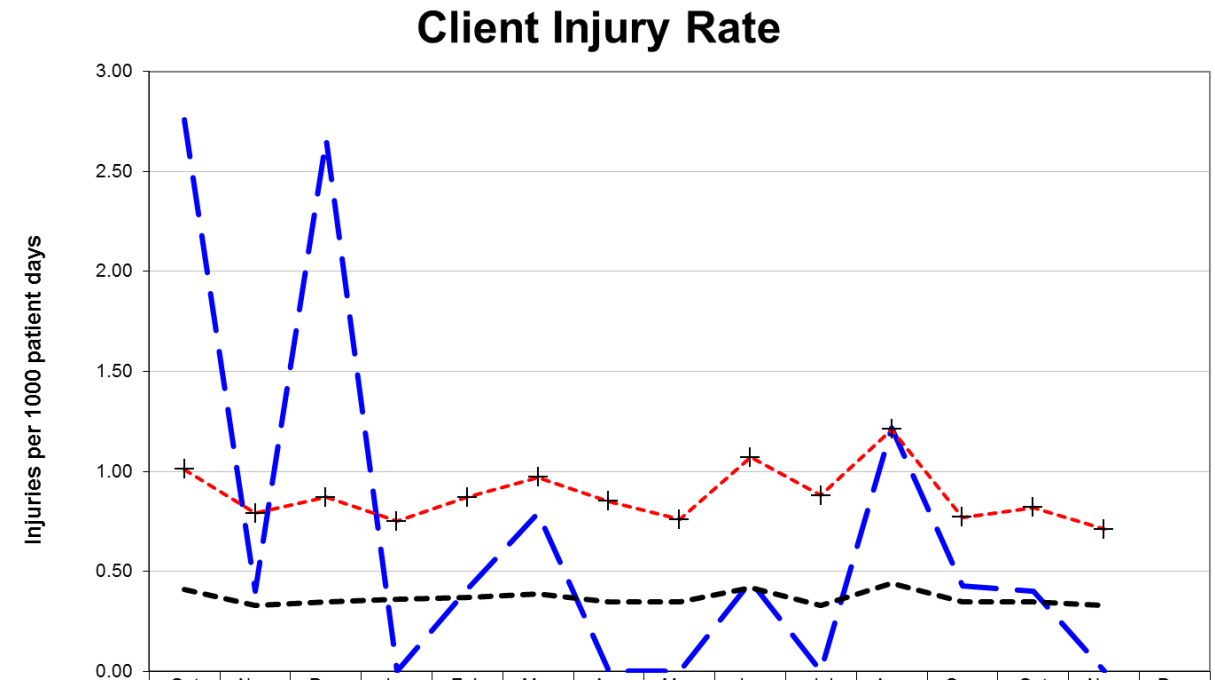
"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- No Treatment – The injury received by a patient may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough to require the treatment of the patient by a licensed practitioner, but does not require hospitalization.
- Hospitalization Required – The injury is so severe that it requires medical intervention and treatment as well as care of the injured patient at a general acute care medical ward within the facility or at a general acute care hospital outside the facility.
- Death Occurred – The injury received was so severe that if resulted in, or complications of the injury lead to, the termination of the life of the injured patient.

The comparative statistics graph only includes those events that are considered "Reportable" by NASMHPD.

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	2.76	0.40	2.66	0.00	0.41	0.79	0.00	0.00	0.45	0.00	1.22	0.43	0.40	0.00	
Ntl Mean	0.41	0.33	0.35	0.36	0.37	0.39	0.35	0.35	0.42	0.33	0.44	0.35	0.35	0.33	
+1 StDev	1.01	0.79	0.87	0.75	0.87	0.97	0.85	0.76	1.07	0.88	1.21	0.77	0.82	0.71	

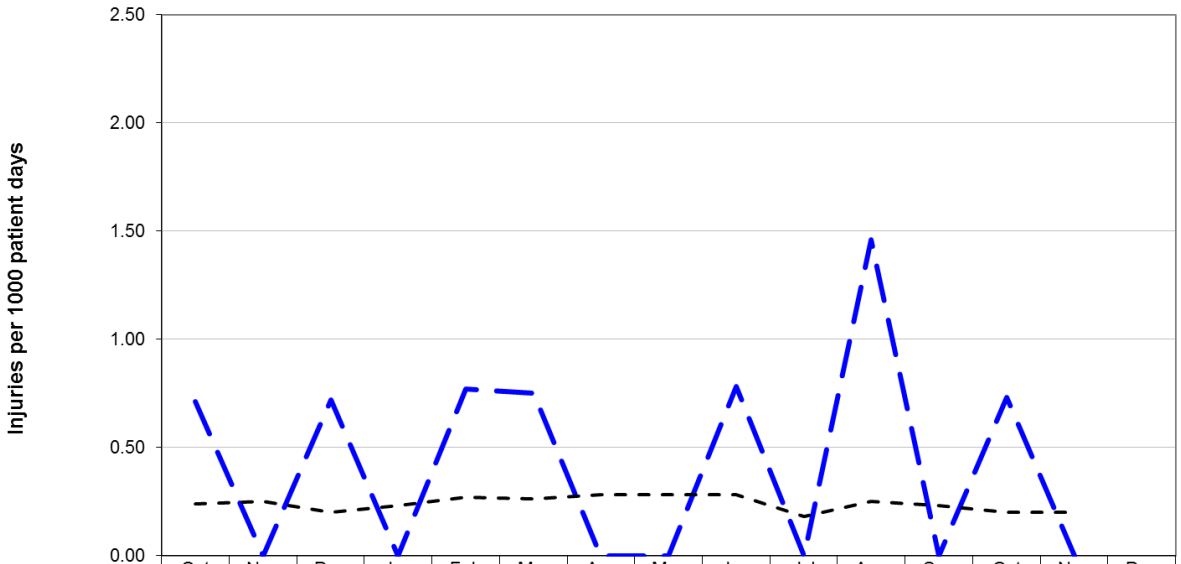
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The following graphs depict the number of patient injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Client Injury Rate

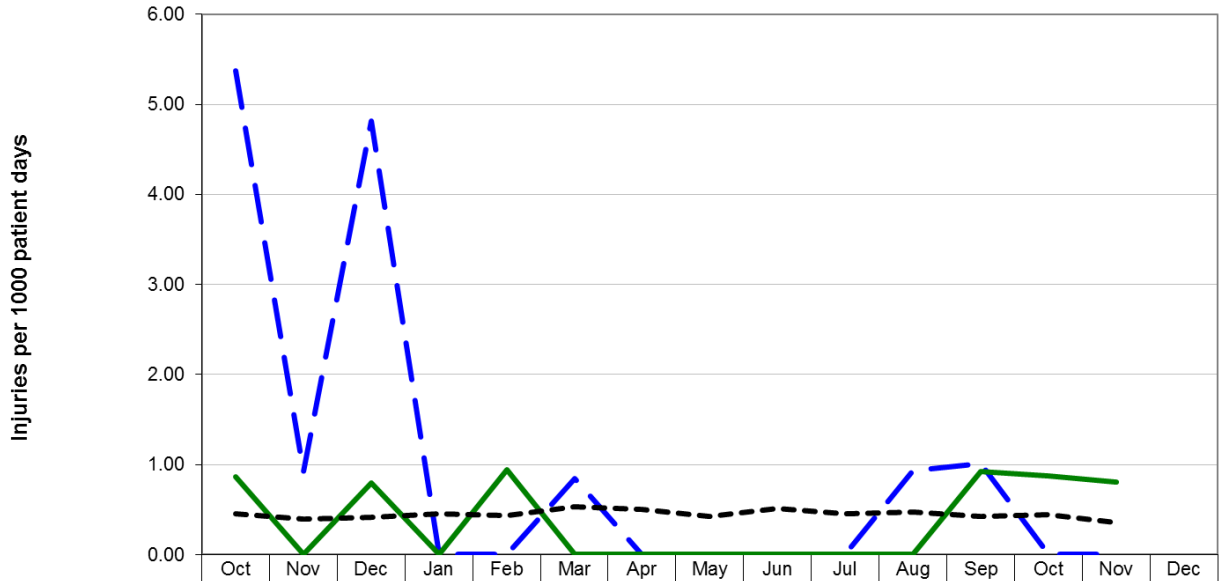
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.71	0.00	0.72	0.00	0.77	0.75	0.00	0.00	0.78	0.00	1.46	0.00	0.73	0.00	
Ntl Mean	0.24	0.25	0.20	0.23	0.27	0.26	0.28	0.28	0.28	0.18	0.25	0.23	0.20	0.20	

Client Injury Rate

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	5.37	0.92	4.81	0.00	0.00	0.84	0.00	0.00	0.00	0.00	0.93	1.01	0.00	0.00	
Dorothea Dix	0.86	0.00	0.80	0.00	0.94	0.00	0.00	0.00	0.00	0.00	0.00	0.92	0.87	0.81	
Ntl Mean	0.45	0.39	0.41	0.45	0.43	0.53	0.50	0.42	0.51	0.45	0.47	0.42	0.44	0.36	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	OCT	NOV	DEC	2Q2016
Accident – Fall	3	4	2	**9**
Accident – Other	1	1	1	**3**
Assault – Patient to Patient	2	0	1	**3**
Injury – Other	2	0	0	**2**
Self-Injurious Behavior	3	2	8	**13**
Total	**11**	**7**	**12**	**30**

Severity of Injury by Month

Severity	OCT	NOV	DEC	2Q2016
No Treatment	3	1	3	**7**
Minor First Aid	6	4	8	**18**
Medical Intervention Required	2	2	1	**5**
Hospitalization Required	0	0	0	**0**
Death Occurred	0	0	0	**0**
Total	**11**	**7**	**12**	**30**

Note: Previous quarterly report numbers may have been higher as they included data on incidents as well as injuries. This report has been modified to only include injuries. Per NASMHPD, injuries occur when harm or damage is done.

Due to changes in reporting standards related to "criminal" events as defined by the "State of Maine Rules for Reporting Sentinel Events", effective February 1, 2013, as defined the by "National Quality Forum 2011 List of Serious Reportable Events," the number of reportable "assaults" that occur as the result of patient interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction. Further information on Fall Reduction Strategies can be found under The Joint Commission Priority Focus Areas section of this report.

Patient Abuse, Neglect, Exploitation, Injury or Death

V33) Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶ 192-201 of the Settlement Agreement.

Type of Allegation	3Q2015	4Q2015	1Q2016	2Q2016	Total
Abuse Verbal	3	5	8	11	**27**
Abuse Physical	14	9	14	11	**48**
Abuse Sexual	10	6	27	9	**52**
Neglect	1	0	3	2	**6**
Coercion/Exploitation	0	3	2	4	**9**
Total	**28**	**23**	**54**	**37**	**142**

Riverview utilizes several vehicles to communicate concerns or allegations related to abuse, neglect, or exploitation:

1. Staff members complete an incident report upon becoming aware of an incident or an allegation of any form of abuse, neglect, or exploitation.
2. Patients have the option to complete a grievance or communicate allegations of abuse, neglect, or exploitation during any interaction with staff at all levels, Peer Support personnel, or the Patient Advocate(s).
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, including:
    - Superintendent and/or AOC
    - Adult Protective Services
    - Guardian
    - Patient Advocate
4. Allegations are reported to the Risk Manager through the incident reporting system and fact-finding or investigations occur at multiple levels. The purpose of this investigation is to evaluate the event to determine if the allegations can be substantiated or not and to refer the incident to the patient's treatment team, hospital administration, or outside entities.
5. When appropriate to the allegation and circumstances, investigations involving law enforcement, family members, or human resources may be conducted.
6. The Human Rights Committee, a group consisting of consumers, family members, providers, and interested community members, and the Medical Executive Committee receive a report on the incident of alleged abuse, neglect, and exploitation monthly.

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on in 2013 and is due for an upcoming reaccreditation visit in 2016. The hospital is currently completing its annual application for an accreditation visit in the fall of 2016.

V35) Riverview maintains its hospital license;

Riverview maintains its licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services. The hospital is licensed through October 31, 2016.

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. Plans are being developed to apply for certification in 2016.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, the accreditation standards of The Joint Commission, and according to a QAPI plan reviewed and approved by the Advisory Board each biennium, and demonstrates through quarterly reports that management uses that data to improve institutional performance, prioritize resources and evaluate strategic operations.

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee, and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is supported by The Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence. The Advisory Board approved the Integrated Plan for Performance Excellence in August 2015.

CONSENT DECREE

Quality Improvement Measures from "Response to the Recommendations from the Report by Elizabeth Jones, Consultant"

Approved by the Maine Superior Court on February 27, 2015

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Prior to his/her treatment team meeting, the class members should be provided the opportunity to meet with a peer specialist in order to prepare for the discussion and to clearly outline any preferences for treatment or discharge planning. Recovery-oriented approaches to treatment, including employment, should be consistently explored with and offered to class member, despite disinterest or refusal at the time of admission.	Treatment Team Coordinators will document all patient engagement in preparation for Treatment Team meetings. The daily chart audit form used by Treatment Team Coordinators/Auditors will be updated by Medical Records to reflect which patients received pre-treatment team meeting engagement.	Patients are engaged prior to their treatment team meeting by a staff member who is very familiar with them. Using a written guide they help the patient focus on how best to use their upcoming treatment meeting time. The hospital is developing further staff training on how to engage patients who are initially resistant to this approach. Treatment Team members do have discussions prior to the patient being involved in the meeting to focus on what maybe the next appropriate step in the class members care. When the patient joins the meeting the focus is engaging them in the discussion to see in what direction the treatment plan will head in. If the goals for the patient are good & appropriate it is ok for them to repeat as long as the interventions change to assist in continue progress towards achieving or maintaining the identified goal. Vocational employment continues to a primary focus for all patients who have court permission to work in the community as well as for patients who have the required level for various jobs at RPC.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		There has been a decrease in number of patients choosing to participate in this opportunity at RPC.
Riverview's leadership should take immediate steps to ensure that the principles of the Recovery model are clearly defined, articulated, and supported throughout each of the four units.	100% of patient records will include documentation of the patient's input into their individualized treatment plan and that the input was used during the Treatment Team meeting.	Implementation of recovery oriented practice has led to a significant reduction in Hands on Holds, Restraints and Seclusions at the hospital. In September 2015, RPC had 8 minutes of restraints for every 1,000 hours of inpatient care. One newly admitted patient, who was very ill, accounted for all of these restraints. She has had no restraints in the past 2 weeks. In September 2015, RPC had 2.24 hours of seclusion per 1,000 hours of inpatient care. One patient accounted for more than half of these hours of seclusion. Riverview has initiated 12 new courses in recovery focused patient care for staff. 4 Clinical Case Conferences have focused on the Recovery Model and care. The hospital has a Recovery Training Specialist to provide training and services to staff. Riverview is a “trauma informed” hospital that works with patients who have experienced many types of trauma in their lives. At intake, all patients complete a questionnaire regarding trauma and history. During New Hire

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		Orientation, all staff are trained in competencies regarding Trauma and Recovery in order to provide the most appropriate level of care.
Riverview's clinical leadership should work with nursing and Mental Health Worker staff to design and implement case conferences or Grand Rounds so that there is greater knowledge, skills, and support in working with class members with challenging behaviors.	The list of case conferences and Grand Rounds will be maintained. The roster of staff participation will be maintained by the Staff and Organizational Development Office. These data will be reported in the Quarterly Report.	The hospital holds a clinical education conference every Thursday at noon. Staff from across all disciplines at the hospital are welcome to participate. 6 patient specific Clinical Case Conferences have been held since January. 4 Recovery Model specific Clinical Conferences have been held since January. 4 Allied Health Clinical Case Conferences on Spirituality, Cultural Differences, Encountering the Other and Compassion Fatigue have been held since January. The conferences include staff from all disciplines at Riverview and when appropriate participation from faculty at Geisel Medical School at Dartmouth College.
Efforts should be initiated to intensify the opportunities offered to class members on the Forensic Units in order to increase their social skills and their knowledge and performance competencies about subjects of interest to them.	Patient Individualized Treatment Plans will contain documentation of participation in all treatment activities. Treatment Team Coordinators will conduct daily chart audits to ensure documentation.	Treatment mall groups change every thirteen weeks. Prior to the new schedule being developed group ideas are requested from patients at the community meetings held on the units. Although specifically not identified with a Trauma label, Psychology and Social Work offer groups that focus on a variety of trauma issues. The

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		titles of the groups are kept discreet to protect the patients in these groups from being stigmatized.
Efforts should be initiated to intensify the opportunities offered to class members on the Forensic Units in order to increase their social skills and their knowledge and performance competencies about subjects of interest to them.	Patient Individualized Treatment Plans will contain documentation of participation in all treatment activities. Treatment Team Coordinators will conduct daily chart audits to ensure documentation.	Treatment mall groups change every thirteen weeks. Prior to the new schedule being developed group ideas are requested from patients at the community meetings held on the units. Although specifically not identified with a Trauma label, Psychology and Social Work offer groups that focus on a variety of trauma issues. The titles of the groups are kept discreet to protect the patients in these groups from being stigmatized.
Riverview should be managed as a single Hospital and the exclusion of Lower Saco from the federal Medicaid program should be reconsidered as an urgent priority.	Completed in November 2014.	In 2013, the hospital was bifurcated in an effort to meet CMS requirements for certification. A decision was made in November 2014 that this separation interfered with the delivery of high quality services at the hospital. Instead of operating two hospitals in one building (Lower Kennebec, Upper Kennebec, and Upper Saco were treated as one hospital with their own distinct staffing and policies and Lower Saco operated as a separate hospital within the same facility). Operating the hospital as it was originally conceived helps ensure that all patients

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Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		have access to all services.
In order to ensure that any limitations are not in violation of the Consent Decree, restrictive practices, including access to outdoor areas, should be reviewed with involvement by class members and mental health workers.	Unit activity logs will be reviewed on a monthly basis to determine whether any limitations in a patient's access to treatment or services occurred. Unit community meetings will include a standing agenda item to review whether any restrictive practices were in place.	All units in which patients can get levels to walk on grounds offer at minimum 4 walking groups per week as part of programming. This does not include times when impromptu walks are offered when there is extra staff on the unit. Lower Saco offers their SCU fitness groups on the unit outside weather permitting. Treatment groups provide Equine Therapy, Pet Therapy, Trail Walking and Sports in the Community as part of the Mall schedule. The hospital has developed an "Open Hospital" model which allows patients (with allowable privileges) to go outside on hospital grounds 3 times per day.
The use of seclusion and restraint requires continued independent review to ensure that there are adequate alternatives designed and implemented for any class member potentially subject to such restrictive measures. Specifically, class members with a history of unacceptable behavior, such as aggression towards peers and/or staff, need to be reviewed again by the treatment team, and, if necessary, by an independent clinical consultant, to	The Risk Manager reviews 100% of cases of seclusion and restraint events including the content and timeliness of events. The hospital sends weekly reports of seclusion and restraint events to the Court Master. The Staff and Organizational Development Office will conduct its first annual review of the MOAB program and present results to Executive Leadership in January 2015.	In January 2014 RPC switched to the *Management of Aggressive Behavior* (MOAB) model. The program was evaluated in the summer and fall of 2015 to measure knowledge, ability and belief about the efficacy and fidelity of the training and implementation. A mixed methodology approach was used in the evaluation. *The first* part of the evaluation consisted of testing the competency of staff in demonstrating knowledge and a

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
determine whether sufficiently individualized interventions are being designed and consistently implemented to replace unacceptable behavior with appropriate alternative behaviors.		ability of MOAB techniques. The staff consistently were unable to demonstrate MOAB techniques. However they quite easily demonstrated NAPPI techniques. It is important to note: The fact that staff reverted back to skills they had learned over many years of practice (NAPPI) is not unusual in this case. Through repetition and practice, motor skills become automatic. The brain in essence "hardwires" the skills into long-term memory. The key is to replace those "muscle memories" with new memories (skills) through the repetition and practice of new skills and/or techniques. Riverview is providing consistent on-going instruction by providing annual MOAB recertification training and skills drills to improve staff competency through opportunities to develop new muscle memories to replace those acquired through NAPPI training. *The second* part of the evaluation consisted on reviewing six videos of patient related events on the Lower Saco unit of the hospital. The reviewers determined that the staff consistently and correctly used MOAB approved

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Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		techniques in all six incidents viewed. MOAB is used at a higher rate on the Lower Saco unit than any other area of the hospital. *The third* part of the evaluation consisted of a survey of employees. Fifty-four employees were interviewed using a seven question survey. Employees indicated a high degree of belief in the level of training they had received and that MOAB was an effective behavior management tool in managing patient behaviors in the hospital.
The reporting requirements by Paragraphs 188 and 189 of the Consent Decree should be completed as mandated.	On an annual basis (starting in January 2015), the Staff and Organizational Development Office will present a report to Executive Leadership at the hospital on the Behavioral Management system being used. The report will include (but is not limited to) information on: Documentation on certification and external reviews of behavioral management system Number of staff trained Number of staff retrained Results of inter-rater reliability tests for trainers	The hospital reviews all seclusion and restraint events. The hospital has been recognized by The Joint Commission for its very low use of restraints over the past two years. There is a review of practices and devices every time there is a seclusion and restraint event at Riverview. The hospital used an outside consultant this year to review the MOAB program to ensure fidelity; the hospital also conducted an assessment of MOAB. The hospital did identify problems and a corrective action plan is being developed. The hospital did introduce a safety transport chair in the hospital this year which allows us to safely move patients between floors; safety transport chairs were reviewed by staff to determine which one best met

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
	Number of staff injuries Number of patient injuries Number of incident reports showing that staff varied from techniques Review of fact-findings or investigations where behavioral management system failed to achieve goals Findings from external reviews of the MOAB program The Risk Manager reviews 100% of all incident reports for seclusion and restraint daily to determine whether further actions are required. A summary report of 100% of all seclusion and restraint events are sent to the Court Master weekly.	the needs of patients and staff at the hospital. Industry standards were used to assure the safety of the chair and all care staff have been trained on its use. The hospital enhanced its already extensive reporting to satisfy the Court Master and Plaintiffs' Counsel needs on Paragraph 189.
In light of the current demographics of admissions to Riverview, the adequacy of staffing requires further independent review. It is highly recommended that staffing ratios be determined by acuity rather than by census on the units.	The hospital will continue to monitor the staffing ratio as defined in the Consent Decree. In addition, the Integrated Quality team will work with Clinical Leadership to establish measurements to test the reliability and validity of data used with acuity based models to ensure that, in addition to meeting the Consent Decree's minimum staffing ratios, staffing is sufficient to carry out Consent Decree requirements.	The challenge of appropriately staffing state-run psychiatric hospitals continues across the country. RPC is competing with the Veteran's Administration and two other hospitals with psychiatric units to recruit and retain the best staff. The hospital is working with the state hospitals in New Hampshire and Vermont on Patient Acuity Scales which will help inform staffing needs. This is a long term project and the hospital is not expecting immediate results of this study.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		Work continues in recruiting for all positions. New positions were funded in the last legislative session and are being filled. The hospital continues to be challenged by trained employees who leave for other state positions which are of less intensity. A recent change in the staffing model has been implemented and is an enormous step in moving toward unit based staffing. An overall of the staffing plan was completed in an effort to "even out" staff scheduling. The hospital hired a new Director of Nursing during the past quarter who is addressing nursing staffing needs.
The use of "float" staff, especially those recently hired at Riverview, requires review in order to reduce the likelihood of risk due to unfamiliarity with and knowledge of the individuals with challenging behaviors or the need for specialized interventions. This review is especially critical for any assignment to the Forensic Units.	100% of new staff on acute units will have received and passed competency based skills training before being assigned.	The Director of Nursing is currently reviewing staffing models to be used in the hospital. In 2015, the hospital will move to a unit-based staffing model to enhance the continuity of care for all patients. To make the staffing model effective the hospital has initiated: Restructured orientation for unit staff – The new plan is to have nurse educator work with the Staff Development office to have all staff receive full orientation before they work on any unit, in order to improve safety for patients and staff alike. Mentoring of new staff by experienced personnel – The Nurse Educator and Nurse Managers will implement a preceptorship program.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		We are seeking assistance from a sister hospital. Regular monitoring of new staff by the nursing education staff – Preceptorship program will be implemented based on an effective preceptor model, and employees who are preceptors will receive additional training and receive a differential in pay. Development of a skills based competency model before staff are assigned to acute units – Nursing will work with Staff Development and RN Managers to develop competencies relative to their hired positions. Riverview Psychiatric Center will be contracting with Applied Management Systems, Donna Watson-Dillon, to review staffing model vs census driven staffing model. As per Elizabeth Jones' recommendation of January 2015, we should be utilizing the training budget of $60,000 to improve staff competencies, which includes preceptorship of all staff.
There should be consideration of supplemental pay for staff assigned to the Lower Saco unit.	The Human Resource office reviews its payroll records to ensure that staff who are eligible for the supplemental pay are receiving it according to Human Resource guidance.	Any adjustment to salary for a group of employees requires bargaining with the appropriate union. The increase for staff working on the lower, more acute units was negotiated with the bargaining unit as part of their current contract. The new contract did not take effect until 9/1/2015.

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Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Discussions should be held with Mental Health Workers and nursing staff to determine what additional measures are required to reduce the pressures experienced by staff and the resulting effects on the class members hospitalized for treatment.	Action steps will be developed based on the results of the DHHS Human Resources survey. The results of the survey and subsequent action steps will be reported to the Quality Improvement Committee and distributed to staff and included in the Quarterly Report.	It was identified that staff, specifically front line staff, face working in stressful and challenging environments due to the acuity of the patients at the hospital. In June, 2015 an Employee Assistance Program training was piloted for Lower Saco Mental Health Workers. Several Mental Health Workers were able to attend reported mixed thoughts on the usefulness of the information. RPC recognized that there are times when a violent event can result in employee physical and/or emotional trauma. In March 2015, RPC developed its own Employee Crisis Support Team to provide support to staff in need. The ECS Team respond to STAT calls and provide support via: restoring the functioning of the organizational structure; clarify the circumstances of the event; assess staff needs, demonstrate care and support, and plan for the immediate future.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Qualification for Mental Health Workers should not be reduced.	100% of Mental Health workers meet and maintain the competencies required for their positions.	The hospital is bound by the minimum requirements of the Bureau of Human Resources for state positions. Currently a Mental Health Worker position requires that the applicant have a high school diploma or equivalency as well as Certified Nursing Assistant or other approved training. The hospital is committed to move from a custodial care focused model to one that is focused on current evidence based practices of bio-psychosocial rehabilitation and recovery. This will necessitate a long term culture change at the hospital, one that is focused on specific skills which center around psychiatric treatment versus custodial care. The hospital believes this expansion into best practice care will require a continued focused on staff education and training. The hospital provides employees the ability to gain, develop and renew skills through: New Employee Orientation, Supplemental Training; Unit/Department Orientation and Training; Annual Mandatory Training; and In Services Training and Education. The Department worked with University of Maine, Augusta to submit a bill

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		provide training to employees. The bill is being considered in the 2016 session.
Continuing effort is required to ensure that all staff understand the mandate for reporting any suspected abuse, neglect, or exploitation of class members.	100% of incidents of abuse, neglect or exploitation are reported to Adult Protective Services. This will be monitored by a monthly review of incident reports. On a bi-monthly basis, the hospital's survey team (comprised of quality improvement staff from both Riverview and Dorothea Dix) will conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.	The Risk Manager continues to verify that all allegations of abuse, neglect or exploitation are reported to Adult Protective Services. All incidents are reviewed. A monthly report is sent to hospital's Human Rights Committee for review. On a monthly review of Incident Reports, the hospital's survey team (comprised of quality improvement staff from both RPC and DDPC) conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.
With consultation from class members and staff on the units, there should an examination of the weaknesses and vulnerabilities that could lead to abuse, neglect and exploitation at Riverview.	A content analysis will be conducted on all debriefing forms to determine themes and patterns. The results from this analysis will be shared with leadership and included in the Quarterly Report. Results of staff surveys will be included in the Quarterly Report. The results of the patient discharge survey will continue to be included in the Quarterly Report.	The hospital's Human Rights Committee has reviewed a patient survey instrument. Members of the Peer Support Office will conduct the survey across the hospital. After completion of the survey, staff will meet with patients and staff on the units about weaknesses and vulnerabilities about abuse, neglect and exploitation. Patient discharge survey data are included in the Quarterly Report.
The Consent Decree language should be modified to specify that timely reporting of abuse and neglect cases should be made to Adult Protective Services (APS), Licensing, the Court Master and Plaintiffs' Counsel.	100% of alleged cases of abuse, neglect, or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocate will receive copies of the validation form received after	The Risk Manager continues to verify that all cases of abuse, neglect, or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocates receive copies of the validation form received after submitting

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
	submitting reports to Adult Protective Services. A monthly summary report of all allegations of abuse, neglect, and exploration is prepared for the hospital's Human Rights Committee. Substantiated claims of abuse, neglect, or exploitation are noted in the hospital's Quarterly Report.	Report to APS. A monthly summary is prepared for the hospital's HRC. Substantiated claims of abuse, neglect, or exploitation are noted in the hospital's Quarterly Report.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change,* which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initiative became operational in March of 1999, when performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

The initial phase of the ORYX initiative provided healthcare organizations a great degree of flexibility, offering greater than 100 measurement systems capable of meeting an accredited organization's internal measurement goals and The Joint Commission's ORYX requirements. This flexibility, however, also presented certain challenges. The most significant challenge was the lack of standardization of measure specifications across systems. Although many ORYX measures appeared to be similar, valid comparisons could only be made between health care organizations using the same measures that were designed and collected based on standard specifications. The availability of over 8,000 disparate ORYX measures also limited the size of some comparison groups and hindered statistically valid data analyses. To address these challenges, standardized sets of valid, reliable, and evidence-based quality measures have been implemented by The Joint Commission for use within the ORYX initiative.

Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set

Driven by an overwhelming request from the field, The Joint Commission was approached in late 2003 by the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) to work together to identify and implement a set of core performance measures for hospital-based inpatient psychiatric services. Project activities were launched in March 2004. At this time, a diverse panel of stakeholders convened to discuss and recommend an overarching initial framework for the identification of HBIPS core performance measures. The Technical Advisory Panel (TAP) was established in March 2005 consisting of many prominent experts in the field.

JOINT COMMISSION

The first meeting of the TAP was held May 2005 and a framework and priorities for performance measures was established for an initial set of core measures. The framework consisted of seven domains:

- Assessment
- Treatment Planning and Implementation
- Hope and Empowerment
- Patient Driven Care
- Patient Safety
- Continuity and Transition of Care
- Outcomes

The current HBIPS standards reflected in this report are designed to reflect these core domains in the delivery of psychiatric care.

JOINT COMMISSION

Admissions Screening (HBIPS 1)

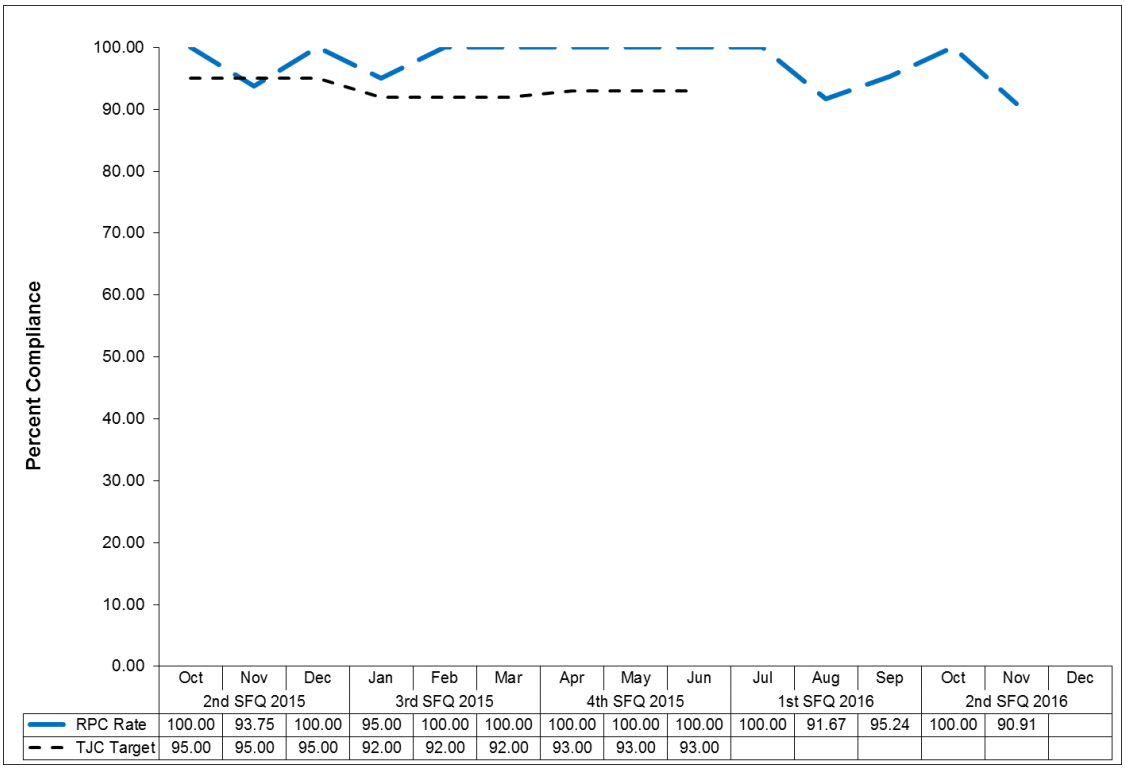
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history, and patient strengths.

Rationale

Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.



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RPC Rate	100.00	93.75	100.00	95.00	100.00	100.00	100.00	100.00	100.00	100.00	91.67	95.24	100.00	90.91	
TJC Target	95.00	95.00	95.00	92.00	92.00	92.00	93.00	93.00	93.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

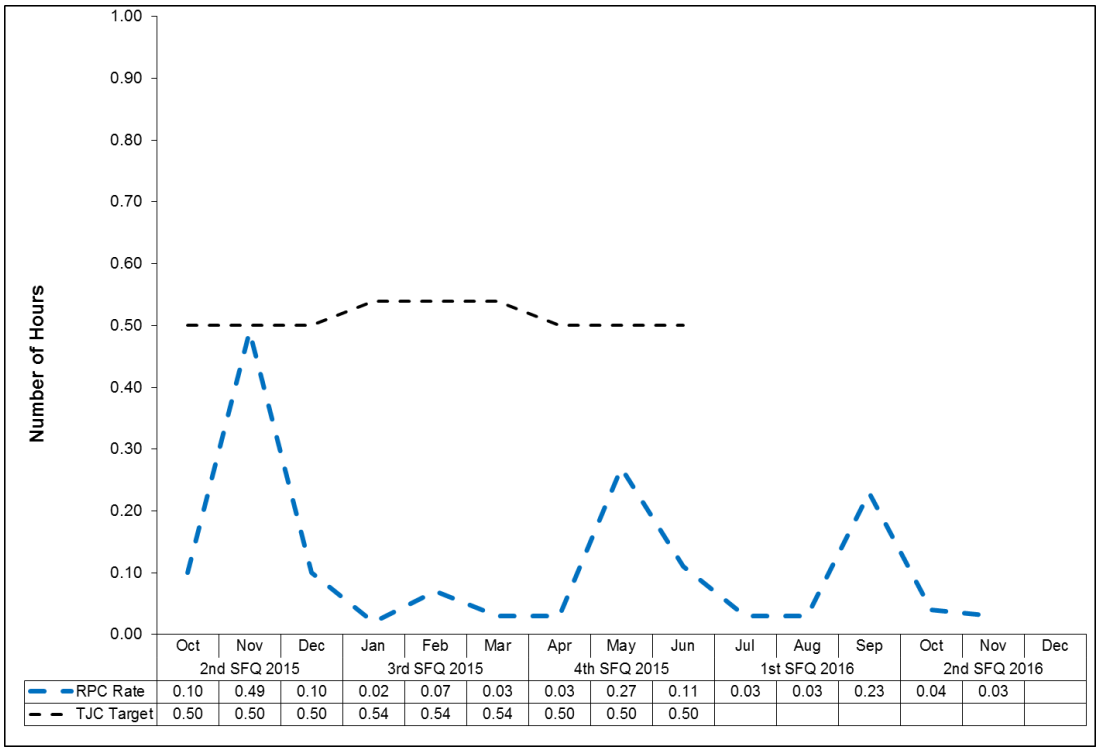
Hours of Use

Description

The total number of hours that all patients, admitted to a hospital-based inpatient psychiatric setting, were maintained in physical restraint.

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



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RPC Rate	0.10	0.49	0.10	0.02	0.07	0.03	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	
TJC Target	0.50	0.50	0.50	0.54	0.54	0.54	0.50	0.50	0.50						

JOINT COMMISSION

Seclusion (HBIPS 3)

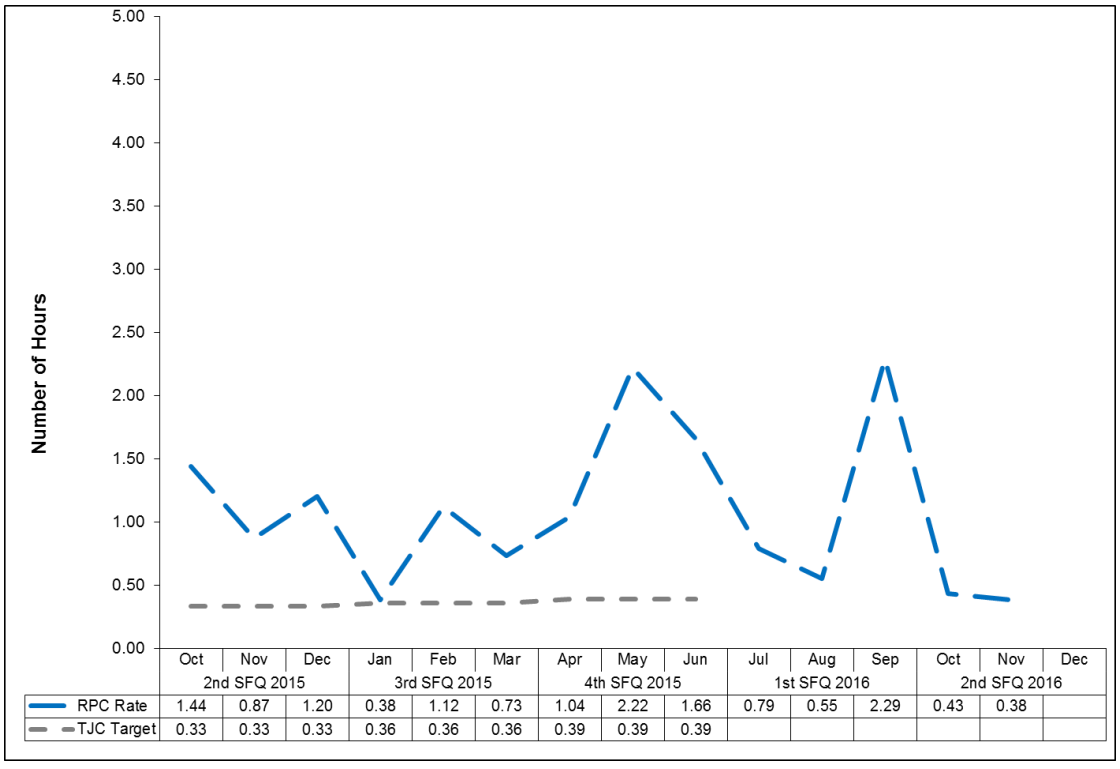
Hours of Use

Description

The total number of hours that all patients, admitted to a hospital-based inpatient psychiatric setting, were held in seclusion.

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



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RPC Rate	1.44	0.87	1.20	0.38	1.12	0.73	1.04	2.22	1.66	0.79	0.55	2.29	0.43	0.38	
TJC Target	0.33	0.33	0.33	0.36	0.36	0.36	0.39	0.39	0.39						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

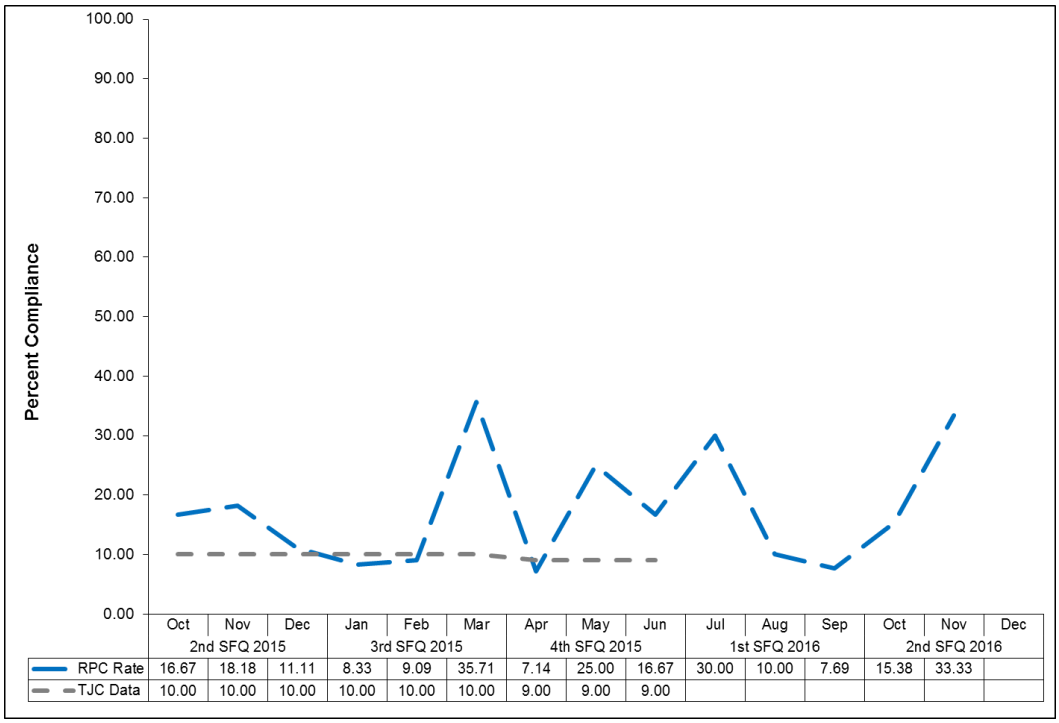
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



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RPC Rate	16.67	18.18	11.11	8.33	9.09	35.71	7.14	25.00	16.67	30.00	10.00	7.69	15.38	33.33	
TJC Data	10.00	10.00	10.00	10.00	10.00	10.00	9.00	9.00	9.00						

JOINT COMMISSION

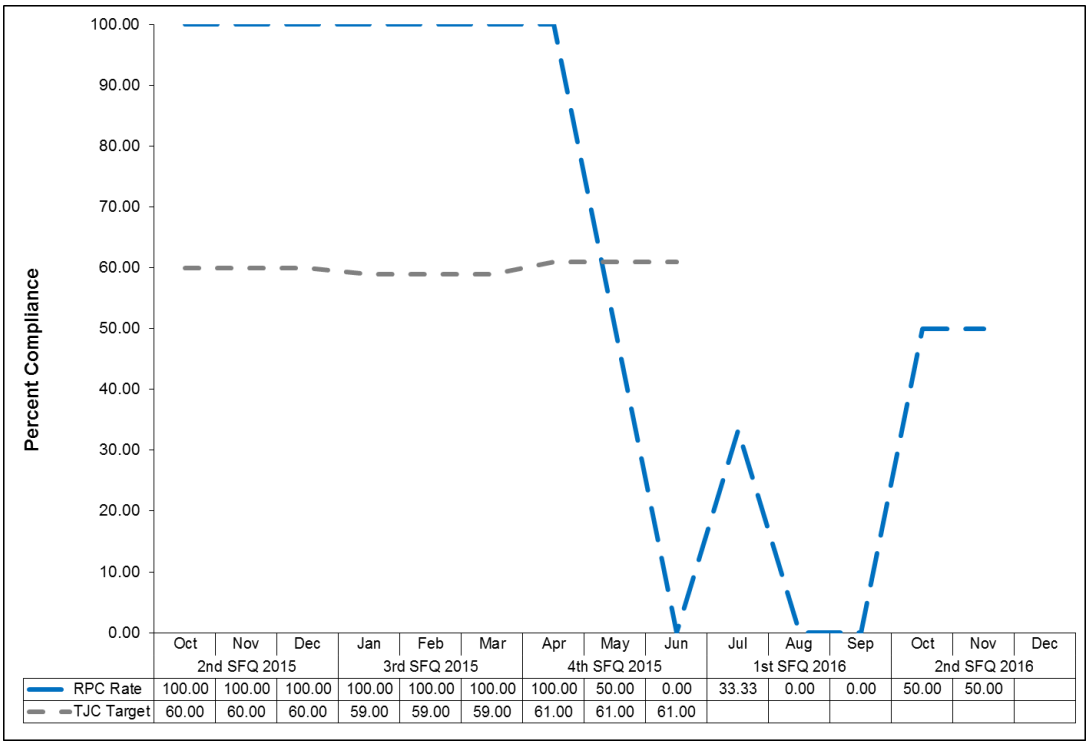
Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

Rationale
Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



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RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	50.00	0.00	33.33	0.00	0.00	50.00	50.00	
TJC Target	60.00	60.00	60.00	59.00	59.00	59.00	61.00	61.00	61.00						

JOINT COMMISSION

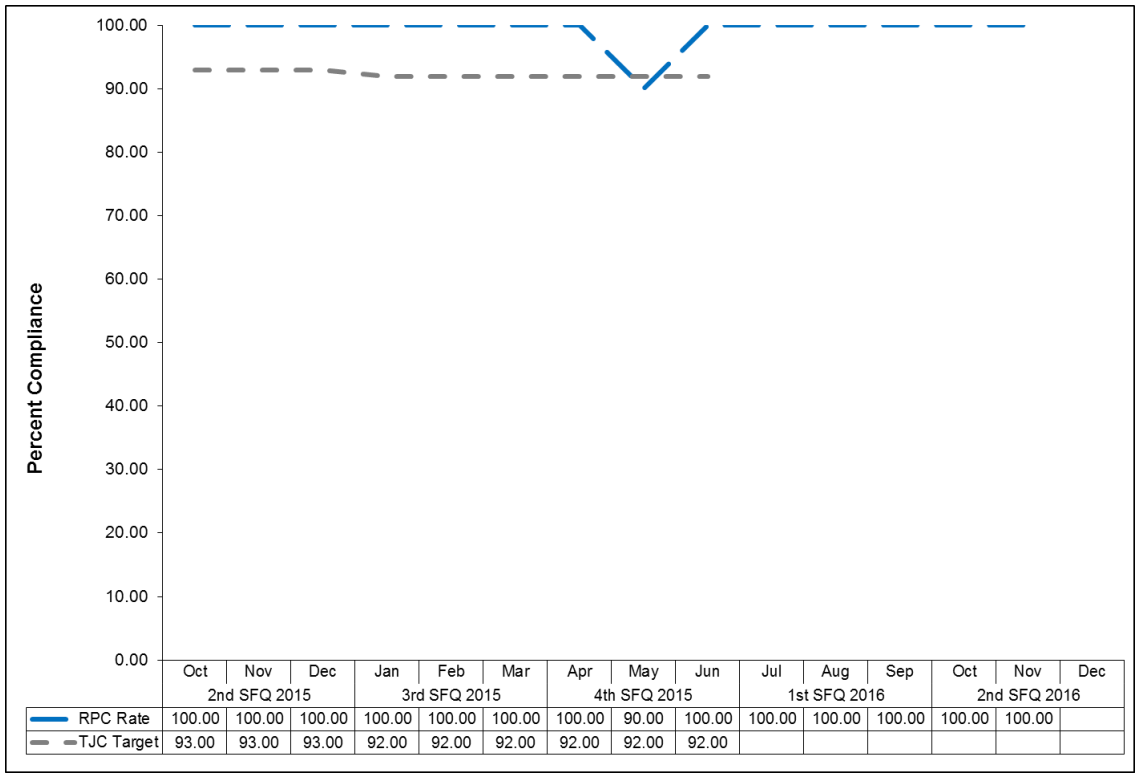
Post Discharge Continuing Care Plan (HBIPS 6)

Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created.

Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).



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RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	90.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	93.00	93.00	93.00	92.00	92.00	92.00	92.00	92.00	92.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

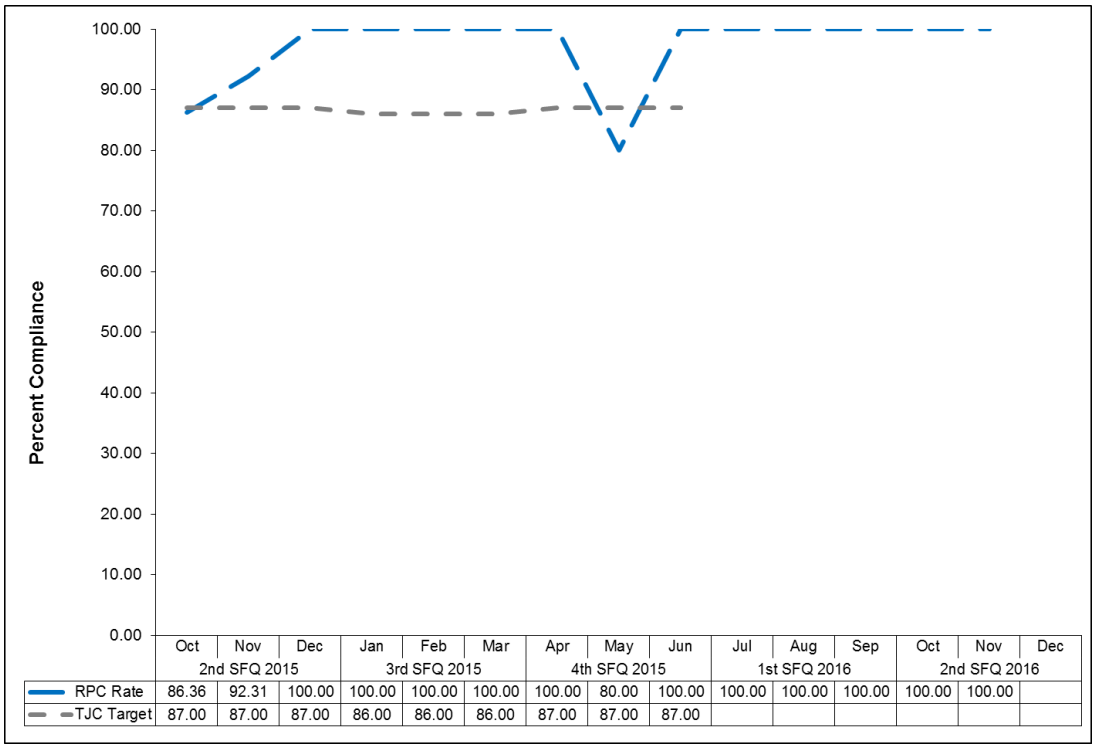
To Next Level of Care Provider on Discharge

Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity.

Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	86.36	92.31	100.00	100.00	100.00	100.00	100.00	80.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	87.00	87.00	87.00	86.00	86.00	86.00	87.00	87.00	87.00						

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Contract Performance Indicators

TJC LD.04.03.09 The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively.

2Q2016 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Robert J. Harper Superintendent	All indicators met standards.
Community Dental, Region II	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Comtec Security	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Cummins Northeast	Richard Levesque Director of Support Services	All indicators met standards.
Dartmouth Medical School	Robert J. Harper Superintendent	All indicators exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	All indicators met standards.
Goodspeed & O'Donnell	Dr. Brendan Kirby Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Maine General Medical Center – Laboratory Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.

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Contractor	Program Administrator	Summary of Performance
MD-IT Transcription Service	Michelle Welch Acting Medical Records Administrator	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Medical Staffing and Services of Maine	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Clinical director	All indicators met or exceeded standards.
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	All indicators met or exceeded standards.
Otis Elevator	Richard Levesque Director of Support Services	All indicators met standards.
Pine Tree Legal Assistance	Dr. Brendan Kirby Clinical Director	No services were provided during this timeframe.
Project Staffing	Cindy Michaud Business Services Manager	All indicators exceeded standards.
Protection One	Richard Levesque Director of Support Services	All indicators met standards.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
UniFirst Corporation	Richard Levesque Director of Support Services	All indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	All indicators met standards.

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Adverse Reactions to Sedation or Anesthesia

TJC PI.01.01.01 EP6: The hospital collects data on the following: adverse events related to using moderate or deep sedation or anesthesia. (See also LD.04.04.01, EP 2)

Capital Community Clinic - Dental Clinic

Dental Clinic Timeout/Identification of Patient

Indicators	3Q2015	4Q2015	1Q2016	2Q2016	Total
National Patent Safety Goals Goal 1: Improve the accuracy of Patient Identification. Capital Community Dental Clinic assures accurate patient identification by: asking the patient to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the Dental Assistant.	**Jan** 100% 4/4 **Feb** 100% 6/6 **Mar** 100% 4/4 **Total** 100% 14/14	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**100%** **25/25**

JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	3Q2015	4Q2015	1Q2016	2Q2016	Total
1. All patients with tooth extractions will be assessed and have teaching post procedure on the following topics, as provided by the Dentist or Dental Assistant: • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The patient, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extraction patients will receive a follow-up phone call from the clinic within 24 hours of procedure to assess for post procedure complications	**Jan** 100% 4/4 **Feb** 100% 6/6 **Mar** 100% 4/4 **Total** 100% 14/14	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**100%** **25/25**

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Infection Control

Responsible Party: Larry Plant, Director of Nursing

I. Measure Name: Hospital Associated Infection (HAI) Rate

Measure Description: Monitor and Measure of Hospital Associated Infections

Measure Type: Quality Assurance

Results							
Target	**Unit**	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY 2014 1 STDV within the mean	7 HAI/IC Rate 1.1	4 HAI/IC Rate 0.83	12 HAI/IC Rate 1.7	6 HAI/ 1 CAI	
Actual Outcome			1 STDV within the mean	1 STDV within the mean			

A **Hospital Acquired Infection (HAI**) is any infection present, incubating or exposed to more than 72 hours **after admission** (unless the patient is off hospital grounds during that time) or declared by a physician, a physician's assistant or advanced practice nurse to be a HAI.

A **Community Acquired Infection (CAI)** is any infection present, incubating or exposed to prior to admission; while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician's assistant, or advanced practice nurse to be a community acquired infection.

An **Idiosyncratic Infection** is any infection that occurs after admission and is the result of the patient's action toward himself or herself.

JOINT COMMISSION

Infections:

Lower Kennebec:
Urinary Tract Infection

Lower Saco:
Pneumonia (CAI)

Lower Saco SCU:
Nickel size wound on left leg

Upper Saco:
Bladder Infection
Folliculitis of Chest

Upper Kennebec:
Left great toe infection x2
H Pylori
Frequent Metastatic Breast Cancer lesions

Data Analysis:
Total Infections: 8
HAI: 7
CAI: 1
Idiosyncratic Infections: 0
Patient Days: 7854

Plan: Ongoing surveillance

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II. Measure Name: Employee Hand Hygiene Rate

Measure Description:

- Staff will observe the hand hygiene practice of nurses as they pass medications. (10 observations per month)
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **7-3 shift.**
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **3-11 shift**

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	80% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	98%* (December 2015 only)			**97**

Data:

Upper Saco Meds – no data
Upper Saco Milieu 7-3 – no data
Upper Saco Milieu 3-11 – no data

Upper Kennebec Meds –100%
Upper Kennebec Milieu 7-3 – 100%
Upper Kennebec Milieu 3-11 – 100%

Lower Kennebec Meds – 100%
Lower Kennebec Milieu 7-3 – 98%
Lower Kennebec Milieu 3-11 – 85%

Lower Saco Meds – 100%
Lower Saco Milieu 7-3 – 100%
Lower Saco Milieu 3-11 – 100%

Infection Control Nurse – position vacant

***Note:** The Infection Control Nurse position was vacated in November 2015. Hand Hygiene data was only available for December 2015 for 3 of the 4 patient units. Data will be provided in the next quarterly report.

Plan: Continue to monitor and measure.

JOINT COMMISSION

III. Measure Name: Assisting Patients with Daily Hygiene

Measure Description: Staff offer hand gel to patients prior to breakfast, lunch, and dinner, thirty (30) days per month.

Measure Type: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	98% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	Not enough data available to quantify			**95%**

Data:
December 2015 data (October and November data is not available):
Lower Saco Main: 100%
Lower Saco SCU: data not available
Upper Saco: Data not available
Lower Kennebec Main: 96%
Lower Kennebec SCU: 85%
Upper Kennebec: 100%

Note: The Infection Control Nurse position was vacated in November 2015. Daily Hygiene data was only available for some of the units. Data will be provided in the next quarterly report.

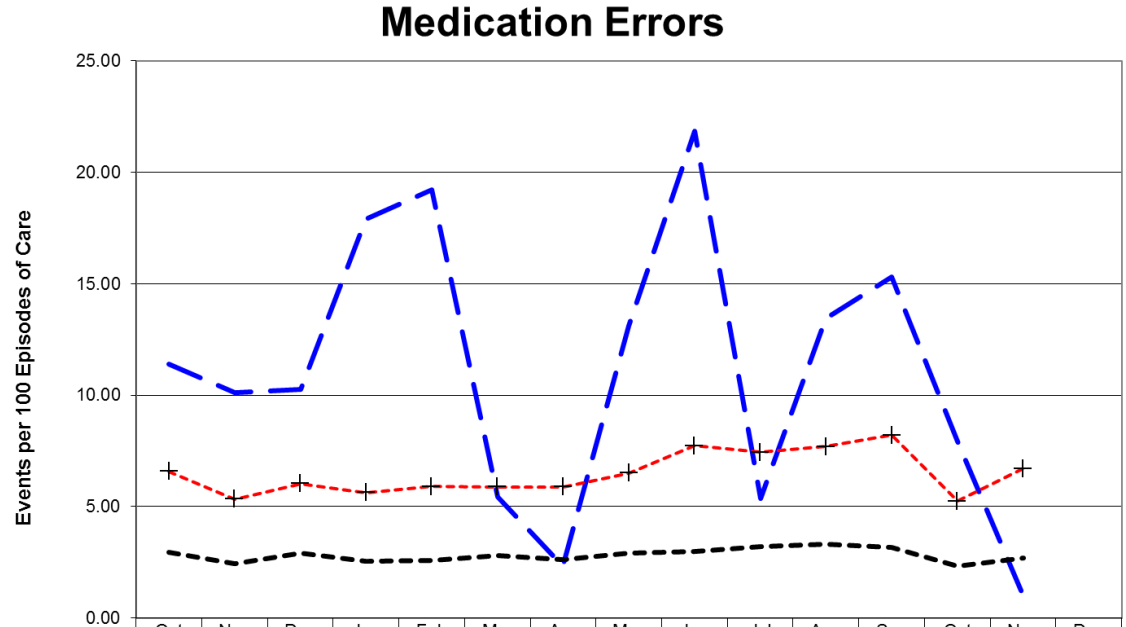
Plan: Continue to monitor and measure.

JOINT COMMISSION

Medication Errors and Adverse Reactions

TJC PI.01.01.01 EP14: The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

TJC PI.01.01.01 EP15: The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	11.40	10.10	10.28	17.92	19.23	5.43	2.33	13.10	21.84	5.38	13.46	15.31	7.92	0.97	
Ntl Mean	2.96	2.45	2.92	2.54	2.60	2.80	2.61	2.92	2.98	3.22	3.32	3.18	2.33	2.69	
+1 StDev	6.58	5.34	6.03	5.63	5.91	5.88	5.89	6.50	7.73	7.44	7.69	8.21	5.25	6.70	

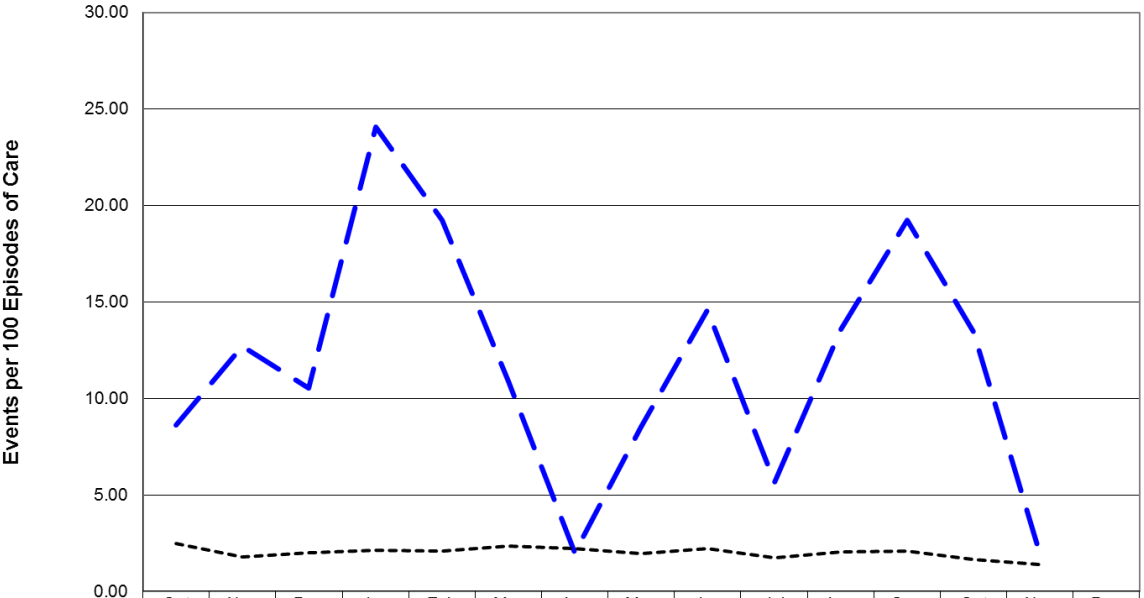
This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

The following graphs depict the number of medication error events that occurred for every 100 episodes of care (duplicated patient count) stratified by forensic or civil classifications. For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

JOINT COMMISSION

Medication Errors

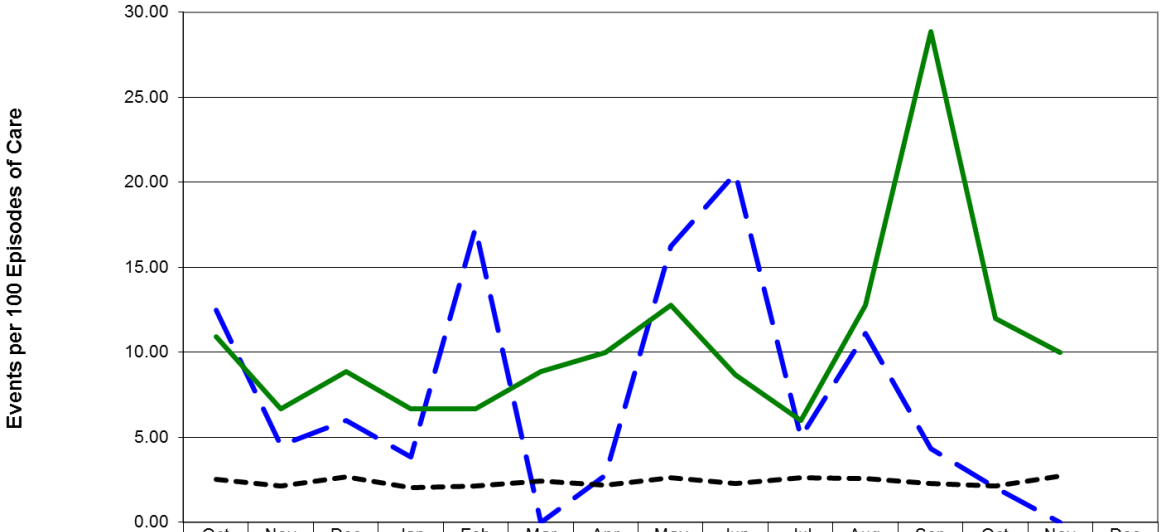
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	8.62	12.73	10.53	24.07	19.23	10.87	2.00	8.51	14.58	5.66	13.56	19.23	13.46	1.96	
Ntl Mean	2.47	1.80	2.00	2.13	2.09	2.33	2.23	1.97	2.24	1.72	2.05	2.07	1.64	1.41	

Medication Errors

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.50	4.55	6.00	3.85	17.31	0.00	2.78	16.22	20.51	5.00	11.11	4.35	2.04	0.00	
Dorothea Dix	10.91	6.67	8.89	6.67	6.67	8.89	10.00	12.77	8.70	6.00	12.77	28.89	12.00	10.00	
Ntl Mean	2.54	2.12	2.68	2.03	2.14	2.42	2.21	2.64	2.30	2.62	2.57	2.28	2.12	2.75	

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Medication Variances

Medication variances are classified according to four major areas related to the area of service delivery. The error must have resulted in some form of variance in the desired treatment or outcome of care. A variance in treatment may involve one incident but multiple medications; each medication variance is counted separately irrespective of whether it involves one error event or many. Medication error classifications include:

Prescribing

- An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to patient level errors are also defined as errors of prescribing in identifying and ordering the appropriate medication to be used in the care of the patient.

Dispensing

- An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.

Administration

- An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

Complex

- An error which resulted from two or more distinct errors of different types is classified as a complex error.

Review, Reporting and Follow-up Process:

The Medication Variances Process Review Team (PRT) meets weekly to evaluate the causation factors related to the medication variances reported on the units and in the pharmacy and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and patient care practices. The team consists of the Clinical Director (or designee), the Director of Nursing (or designee), the Director of Pharmacy (or designee), and the Clinical Risk Manager or the Performance Improvement Manager.

The activities and recommendations of the Medication Variances PRT are reported monthly to the Integrated Performance Excellence Committee.

JOINT COMMISSION

Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
12/15/2014	N	WRONG FORM X7	N	N	N	LKM	3	0	6
4/5/2015	N	WRONG DRUG X3	Y	N	N	US	4	0	4
5/18/2015	N	WRONG FORM	Y	N	N	LKM	2	0	6
5/19/2015	N	WRONG DOSE X3	N	N	N	LKM	3	1	6
6/19/2015	Y	OMISSION	N	N	N	US	2	0	3
6/20/2015	N	EXTRA DOSE	N	N	N	US	2	1	3
6/27/2015	Y	OMISSION	N	N	N	LSS	2	0	8
7/31/2015	Y	OMISSION	Y	N	N	LSM	3	1	9
8/3/2015	N	WRONG DOSE	Y	N	N	LSM	3	1	7
8/8/2015	N	WRONG TIME	Y	N	N	LSM	2	1	7
8/10/2015	N	EXTRA DOSE	N	N	N	US	2	1	3
8/26/2015	N	WRONG TIME	N	N	N	US	2	0	3
8/28/2015	Y	OMISSION	N	Y	N	LKS	3	1	7
8/29/2015	Y	OMISSION	Y	N	N	LKM	2	0	6
8/29/2015	Y	OMISSION	Y	N	N	LKM	2	0	6
8/30/2015	Y	OMISSION X2	N	Y	N	US	2	1	3
9/4/2015	N	WRONG DOSE	N	N	N	LKM	3	1	7
9/4/2015	Y	OMISSION X2	N	Y	N	LSS	3	1	7
9/4/2015	N	EXTRA DOSE	N	N	N	LSS	2	0	6
9/7/2015	N	WRONG ROUTE	N	N	N	LSS	3	1	7
9/9/2015	N	WRONG DOSE	N	N	N	UK	3	1	3
9/10/2015	N	WRONG DOSE X2	Y	N	N	LKM	2	1	7
9/10/2015	Y	OMISSION	N	N	N	LSM	2	1	8
9/11/2015	N	WRONG DOSE X2	Y	N	N	LKM	3	1	7
9/14/2015	N	EXTRA DOSE	N	Y	N	LSM	2	1	7
9/15/2015	N	WRONG TIME	N	Y	N	LSM	3	1	7
9/16/2015	N	WRONG FORM	N	N	N	UK	2	1	3
9/16/2015	N	WRONG FORM	N	N	N	UK	2	1	3
9/17/2015	N	WRONG TIME	N	N	N	LSM	3	1	7
9/18/2015	Y	OMISSION	N	Y	N	US	3	1	4
9/21/2015	N	EXTRA DOSE X2	Y	N	N	LSM	3	1	8
9/25/2015	Y	OMISSION	N	N	Y	LKM	2	1	5
9/25/2015	Y	OMISSION X3	N	N	N	LSM	3	1	7
9/25/2015	Y	OMISSION X3	N	N	N	LSM	3	1	8

JOINT COMMISSION

10/3/2015	N	WRONG TIME	N	Y	N	US	1	1	3
10/4/2015	Y	OMISSION	Y	N	N	LSM	2	1	7
10/5/2015	Y	OMISSION				LKM			
10/5/2015	Y	OMISSION X2	Y	N	N	US	2	0	3
10/6/2015	Y	OMISSION X10	N	N	N	US	2	1	3
10/7/2015	N	EXTRA DOSE X4				LKM			
10/12/2015	N	WRONG DOSE	Y	N	N	LKM	2	0	6
10/15/2015	N	WRONG FORM	N	N	N	LKM	4	0	8
10/15/2015	N	WRONG TIME	N	N	N	LKM	3	1	7
10/15/2015	Y	OMISSION	N	N	N	LSM	3	1	7
10/19/2015	Y	OMISSION	N	N	N	LKS	3	1	7
10/25/2015	N	WRONG DRUG	N	N	N	LKM	2	1	7
10/25/2015	Y	OMISSION	N	N	N	UK	2	0	3
10/25/2015	Y	OMISSION	N	N	N	UK	2	0	3
10/26/2015	Y	OMISSION	N	N	N	LKM	3	1	7
11/7/2015	N	EXTRA DOSE	N	N	N	LKS	2	0	3
11/8/2015	Y	OMISSION	N	N	N	LKM	2	1	6
11/13/2015	N	EXTRA DOSE X2	Y	N	N	LKS	2	1	6
11/13/2015	Y	OMISSION	N	N	N	US	2	1	3
12/4/2015	N	EXTRA DOSE	N	N	N	US	1	0	4
12/29/2015	N	EXTRA DOSE	Y	N	N	LSS	1	0	3
Totals:	**40**		**22**	**9**	**1**	**LS: 23**	**US: 25**	**LK: 35**	**UK: 5**
Percent	**45%**	**88 Total Errors**	**25%**	**10%**	**1%**	**26%**	**28%**	**40%**	**6%**

*Each dose of medication is documented as an individual variance (error)

Type of Error	# of Errors
Extra Dose	15
Omission	40
Wrong Dose	11
Wrong Drug	4
Wrong Form	11
Wrong Time	6
Wrong Route	1

JOINT COMMISSION

Dispensing Process

Measure	Unit	Baseline 2014	Goal	3Q 2015	4Q 2015	1Q 2016	2Q 2016
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.875%	0% Target: Actual:	 0% 0%	 0% 0%	 0% 0%	 0% 0%
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: Actual:	 0 0	 0 0	 0 0	 0 0
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug discrepancies.	All	0/mo	0 Target: Actual:	 0 0 (0/ mo)	 0 0 (0/ mo)	 0 0 (0/ mo)	 0 0 (0/ mo)
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events and other management data.	Rx	8/year	0 Target: Actual:	 0 2	 0 3	 0 0	 0 0
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	99/ quarter	100% Target: Actual:	 100% 73	 100% 56	 100% 31	 100% 144
6. Psychiatric Emergency Process: Monthly audit of all psych emergencies measures against 9 criteria.	All	100%	100% Target: Actual:	 100% 93%	 100% 94%	 100% 78%	 100% 98%
7. Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx	100%	100% Target: Actual:	 100% 100%	 100% 100%	 100% 100%	 100% 100%

Note: Previous figures for Criteria #3 were reported on the number of discrepancies discovered in Pyxis. This number is not reflective of the number of controlled substances lost, but rather the number of times a simple mistake, such as a miscount, occurred. To ensure accuracy pharmacy staff reviewed past logs of controlled substances and found no substances unaccounted for.

JOINT COMMISSION

Inpatient Consumer Survey

TJC PI.01.01.01 EP16: The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, and services.

The **Inpatient Consumer Survey (ICS)** is a standardized national survey of customer satisfaction. The National Association of State Mental Health Program Directors Research Institute (NRI) collects data from state psychiatric hospitals throughout the country in an effort to compare the results of patient satisfaction in six areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, Environment, and Empowerment.

Inpatient Consumer Survey (ICS) has been recently endorsed by NQF, under the Patient Outcomes Phase 3: Child Health and Mental Health Project, as an outcome measure to assess the results, and thereby improve care provided to people with mental illness. The endorsement supports the ICS as a scientifically sound and meaningful measure to help standardize performance measures and assures quality of care.

Rate of Response for the Inpatient Consumer Survey:

Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients on their perception of the care provided to then while at Riverview Psychiatric Center.

The Peer Support group has identified a need to improve the overall response rate for the survey. This process improvement project is defined and described in the section on Patient Satisfaction Survey Return Rate of this report.

There is currently no aggregated date on a forensic stratification of responses to the survey.

Note: When the Riverview field is blank for a month it means that no patients responded to the survey questions on that page in that particular month.

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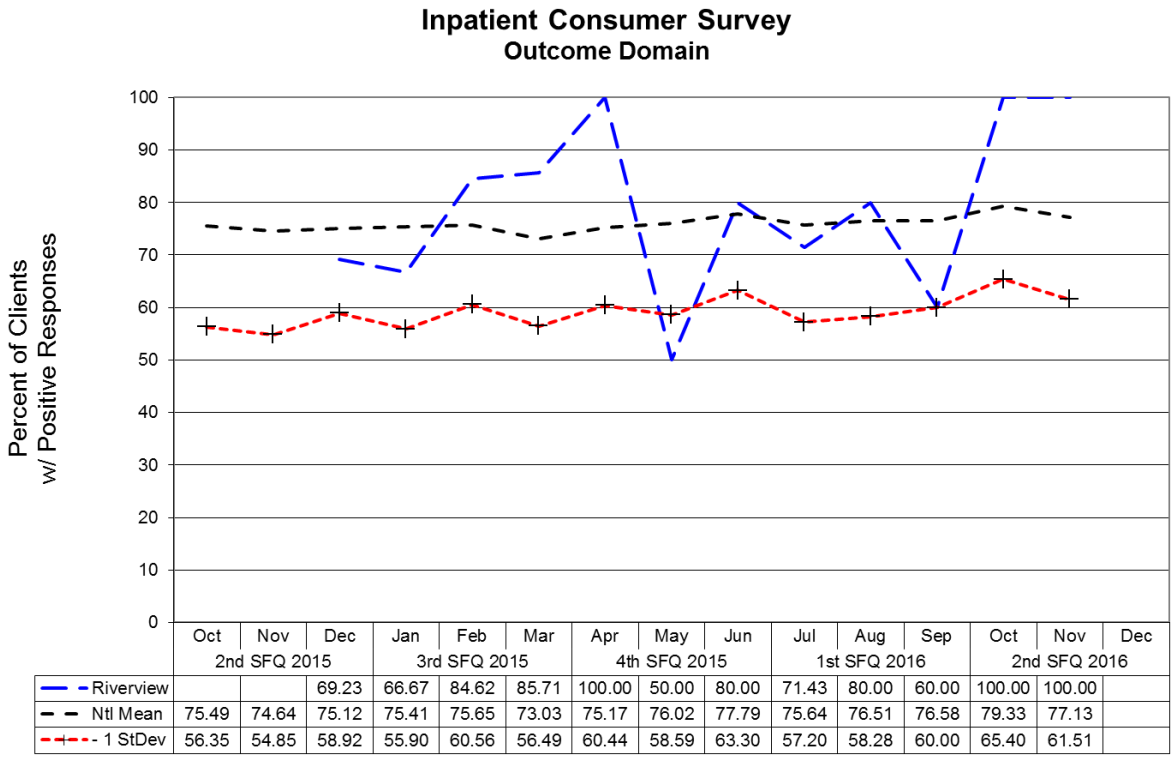

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			69.23	66.67	84.62	85.71	100.00	50.00	80.00	71.43	80.00	60.00	100.00	100.00	
Ntl Mean	75.49	74.64	75.12	75.41	75.65	73.03	75.17	76.02	77.79	75.64	76.51	76.58	79.33	77.13	
1 StDev	56.35	54.85	58.92	55.90	60.56	56.49	60.44	58.59	63.30	57.20	58.28	60.00	65.40	61.51	

Outcome Domain Questions:

1. I am better able to deal with crisis.
2. My symptoms are not bothering me as much.
3. I do better in social situations.
4. I deal more effectively with daily problems.

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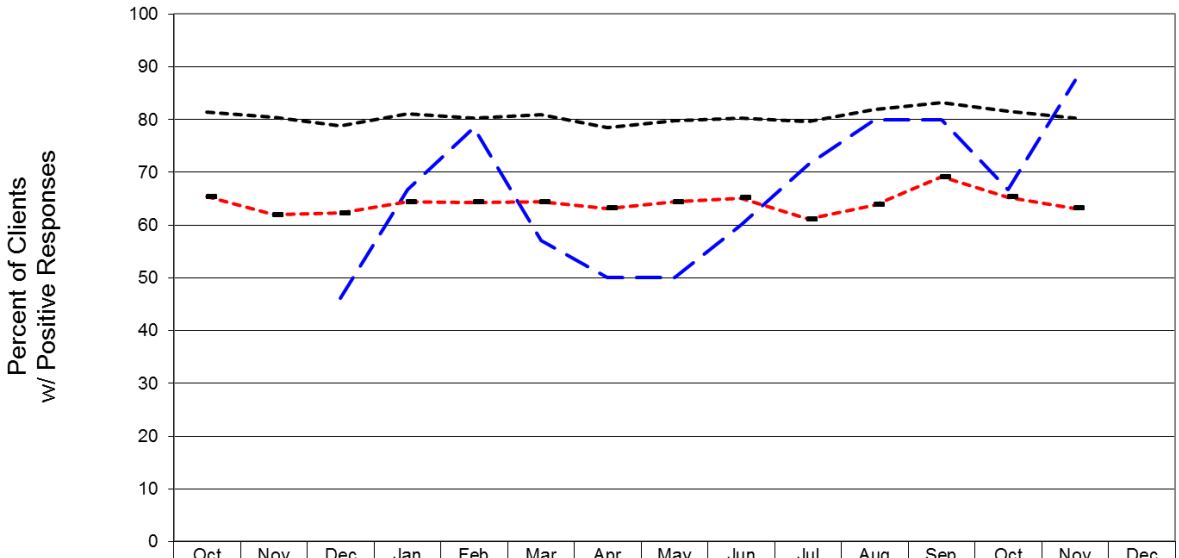
Inpatient Consumer Survey
Dignity Domain



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			46.15	66.67	78.57	57.14	50.00	50.00	60.00	71.43	80.00	80.00	66.67	87.50	
Ntl Mean	81.44	80.38	78.90	81.15	80.24	80.93	78.48	79.75	80.28	79.58	81.92	83.22	81.66	80.30	
1 StDev	65.36	61.96	62.32	64.41	64.30	64.43	63.18	64.37	65.16	61.14	63.82	69.11	65.34	63.19	

Dignity Domain Questions:

1. I was treated with dignity and respect.
2. Staff here believed that I could grow, change and recover.
3. I felt comfortable asking questions about my treatment and medications.
4. I was encouraged to use self-help/support groups.

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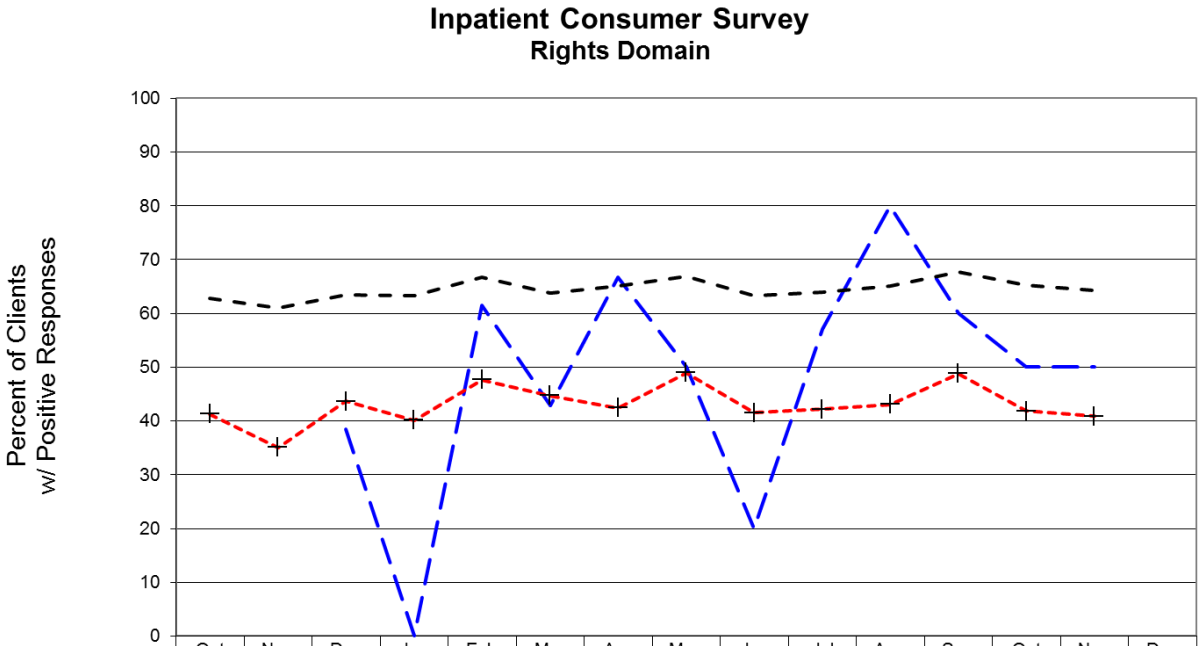
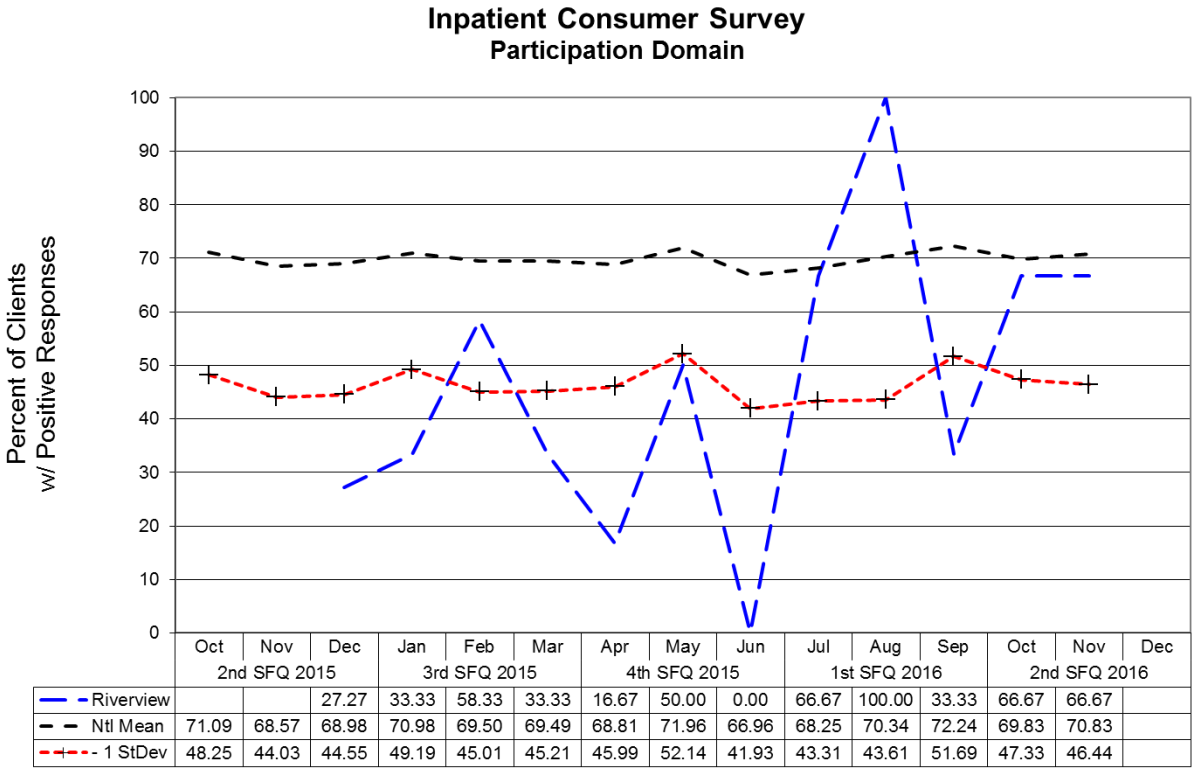


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			38.46	0.00	61.54	42.86	66.67	50.00	20.00	57.14	80.00	60.00	50.00	50.00	
Ntl Mean	62.73	61.01	63.46	63.23	66.69	63.76	65.17	66.95	63.35	63.94	65.03	67.71	65.25	64.32	
1 StDev	41.29	35.04	43.63	40.14	47.65	44.68	42.40	48.95	41.50	42.18	43.06	48.76	41.89	40.85	

Rights Domain Questions:

1. I felt free to complain without fear of retaliation.
2. I felt safe to refuse medication or treatment during my hospital stay.
3. My complaints and grievances were addressed.

JOINT COMMISSION

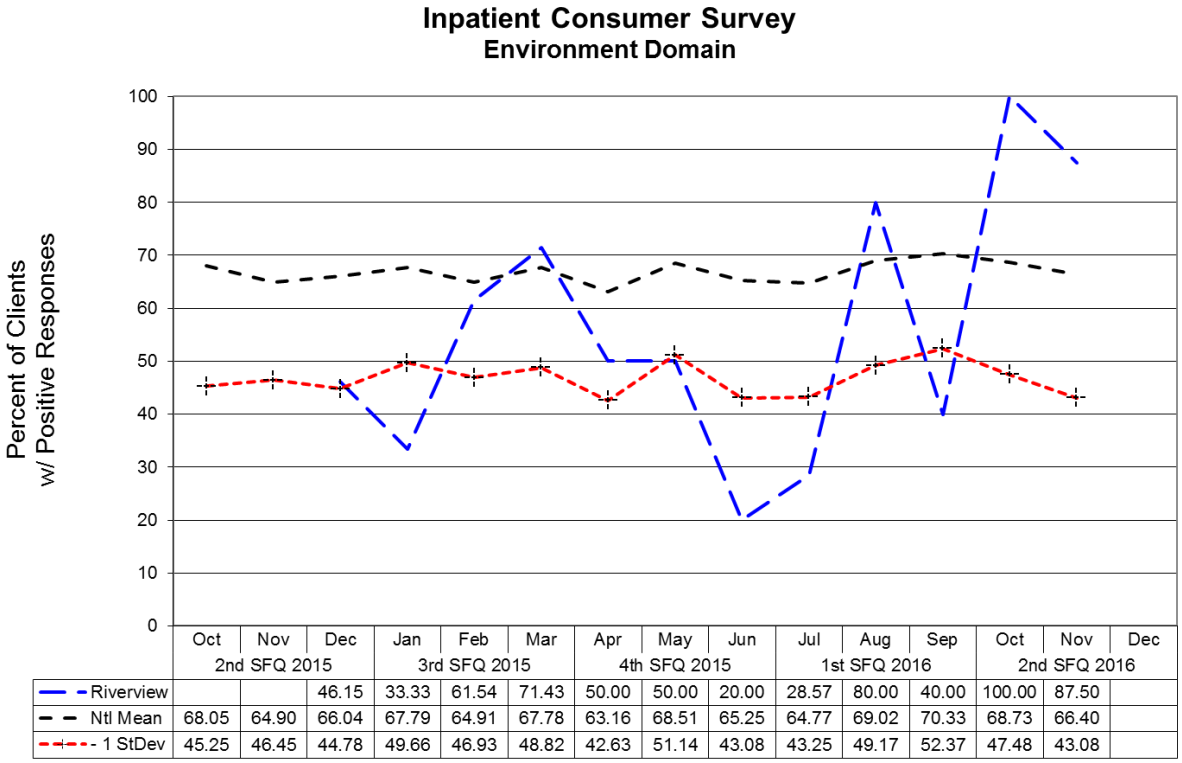


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			27.27	33.33	58.33	33.33	16.67	50.00	0.00	66.67	100.00	33.33	66.67	66.67	
Ntl Mean	71.09	68.57	68.98	70.98	69.50	69.49	68.81	71.96	66.96	68.25	70.34	72.24	69.83	70.83	
1 StDev	48.25	44.03	44.55	49.19	45.01	45.21	45.99	52.14	41.93	43.31	43.61	51.69	47.33	46.44	

Participation Domain Questions:

1. I participated in planning my discharge.
2. Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.
3. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

JOINT COMMISSION

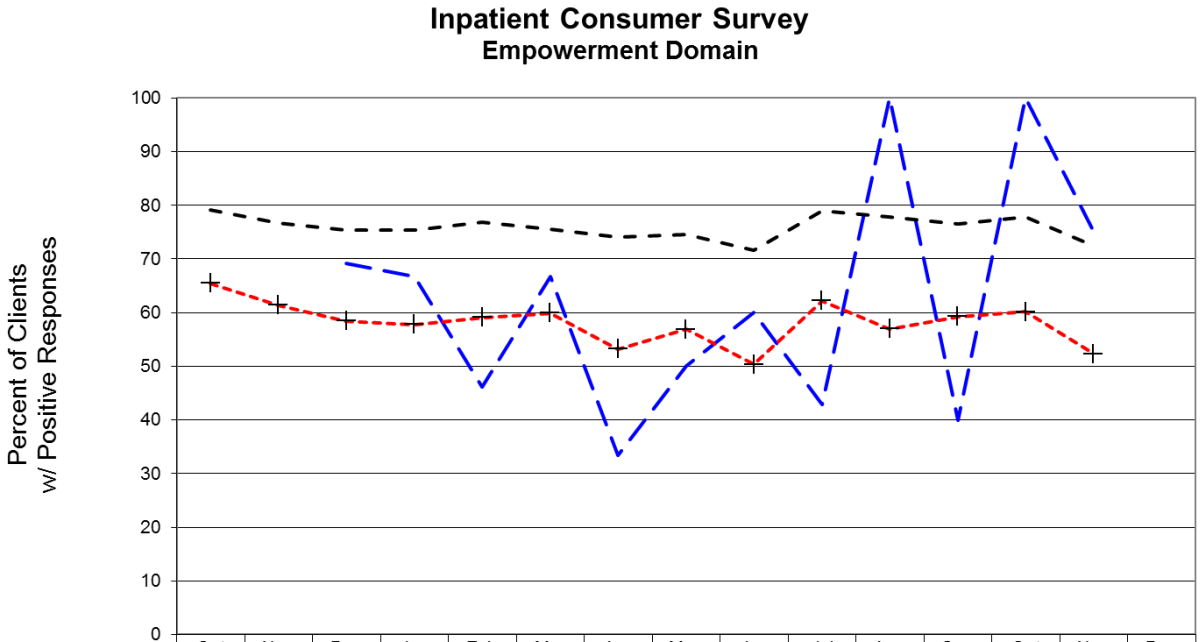


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			46.15	33.33	61.54	71.43	50.00	50.00	20.00	28.57	80.00	40.00	100.00	87.50	
Ntl Mean	68.05	64.90	66.04	67.79	64.91	67.78	63.16	68.51	65.25	64.77	69.02	70.33	68.73	66.40	
1 StDev	45.25	46.45	44.78	49.66	46.93	48.82	42.63	51.14	43.08	43.25	49.17	52.37	47.48	43.08	

Environment Domain Questions:

1. The surroundings and atmosphere at the hospital helped me get better.
2. I felt I had enough privacy in the hospital.
3. I felt safe while I was in the hospital.
4. The hospital environment was clean and comfortable.

JOINT COMMISSION



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			69.23	66.67	46.15	66.67	33.33	50.00	60.00	42.86	100.00	40.00	100.00	75.00	
Ntl Mean	79.07	76.62	75.44	75.31	76.90	75.61	74.07	74.60	71.59	78.92	77.81	76.55	77.89	72.37	
1 StDev	65.47	61.42	58.47	57.81	59.08	59.87	53.25	56.91	50.35	62.23	56.98	59.23	60.14	52.32	

Empowerment Domain Questions:

1. I had a choice of treatment options.
2. My contact with my Doctor was helpful.
3. My contact with nurses and therapists was helpful.

JOINT COMMISSION

Fall Reduction Strategies

TJC PI.01.01.01 EP38: The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

TJC PC.01.02.08: The hospital assesses and manages the patient's risks for falls.
EP01: The hospital assesses the patient's risk for falls based on the patient population and setting.
EP02: The hospital implements interventions to reduce falls based on the patient's assessed risk.

The Falls Risk Management Team has been created to be facilitated by a member of the team with data supplied by the Risk Manager. The role of this team is to conduct root cause analyses on each of the falls incidents and to identify trends and common contributing factors and to make recommendations for changes in the environment and process of care for those patients identified as having a high potential for falls.

Type of Fall by Patient and Month:

Fall Type	Patient	OCT	NOV	DEC	2Q2016
Un-witnessed	MR175		2		**2**
	MR5053		1	1	**2**
	MR5901			1	**1**
	MR6354			1	**1**
	MR6714	1			**1**
	MR7832*	2			**2**
	Totals	**3**	**3**	**3**	**9**
Fall Type	**Patient**	**OCT**	**NOV**	**DEC**	**2Q2016**
Witnessed	MR156			1	**1**
	MR3374			1	**1**
	MR7665	1	2		**3**
	MR7832*		1		**1**
	MR7837		1		**1**
	Totals	**1**	**4**	**2**	**7**

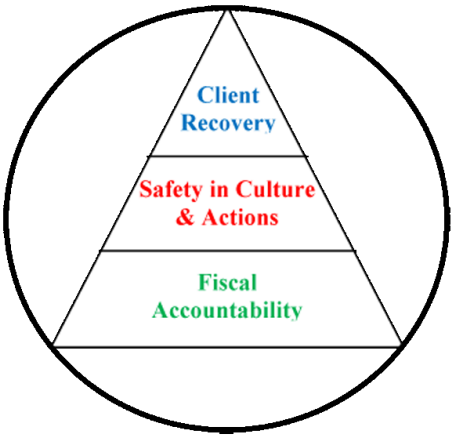
*Patients have experienced witnessed and un-witnessed falls during the reporting quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Process Improvement Plans

Priority Focus Areas for Strategic Performance Excellence

In an effort to ensure that quality management methods used within the Maine Psychiatric Hospitals System are consistent with modern approaches of systems engineering, culture transformation, and process focused improvement strategies and in response to the evolution of Joint Commission methods to a more modern systems-based approach instead of compliance-based approach



Building a framework for patient recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of…

- The conviction that staff members are concerned with doing the right thing in support of patient rights and recovery;
- A philosophy that promotes an understanding that errors most often occur as a result of deficiencies in system design or deployment;
- Systems and processes that strive to evaluate and mitigate risks and identify the root cause of operational deficits or deficiencies without erroneously assigning blame to system stakeholders;
- The practice of engaging staff members and patients in the planning and implementing of organizational policy and protocol as a critical step in the development of a system that fulfills ethical and regulatory requirements while maintaining a practicable workflow;
- A cycle of improvement that aligns organizational performance objectives with key success factors determined by stakeholder defined strategic imperatives;
- Enhanced communications and collaborative relationships within and between cross-functional work teams to support organizational change and effective process improvement;
- Transitions of care practices where knowledge is freely shared to improve the safety of patients before, during, and after care;
- A just culture that supports the emotional and physical needs of staff members, patients, and family members that are impacted by serious, acute, and cumulative events.

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

Protect and enhance the health and well-being of Maine people
Promote independence and self sufficiency
Protect and care for those who are unable to care for themselves
Provide effective stewardship for the resources entrusted to the Department

Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

Ensure and Promote Fiscal Accountability by…
Identifying and employing efficiency in operations and clinical practice
Promoting vigilance and accountability in fiscal decision-making.

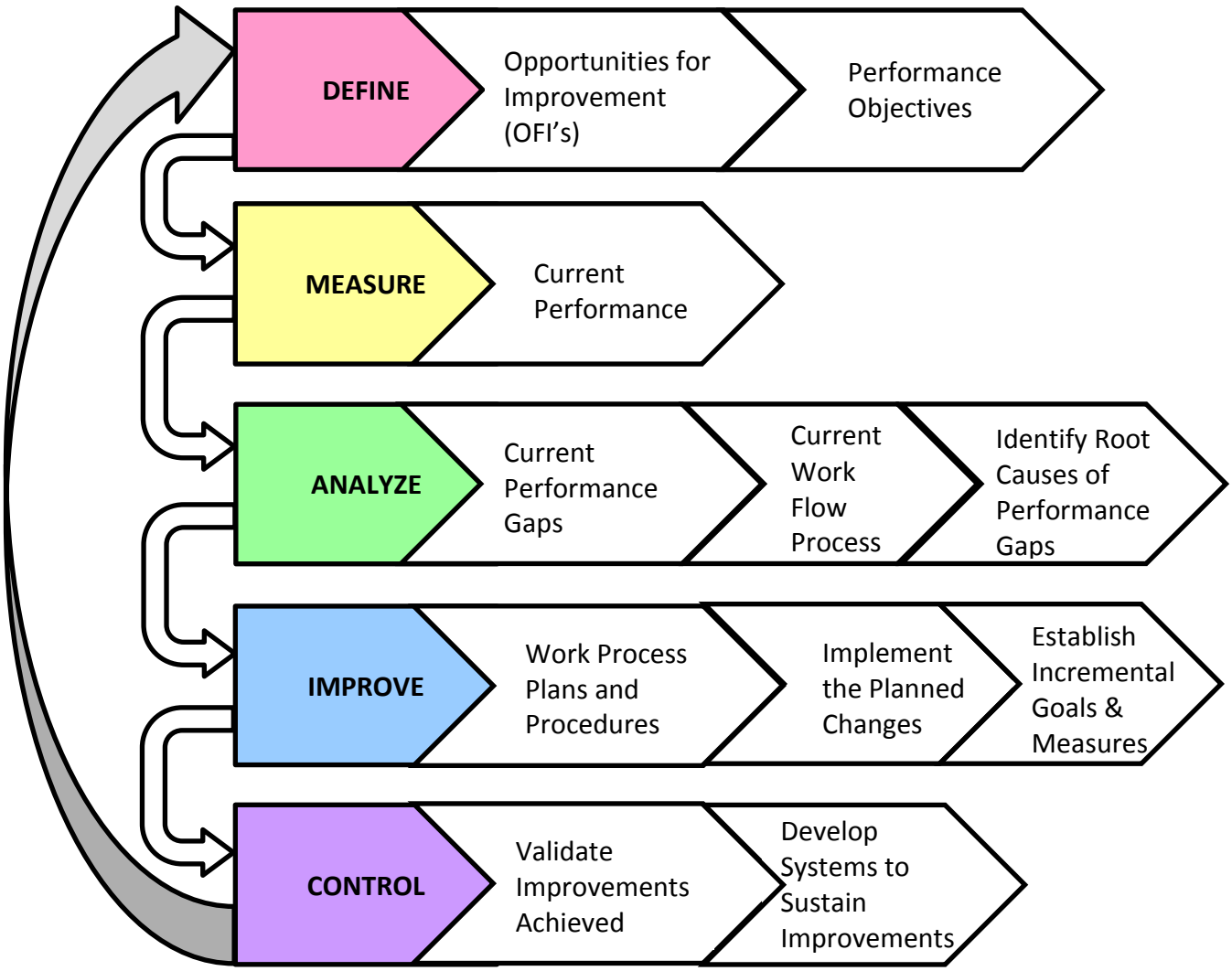
Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staff Members

Enhance Patient Recovery by…
Develop Active Treatment Programs and Options for Patients
Supporting patients in their discovery of personal coping and improvement activities.

STRATEGIC PERFORMANCE EXCELLENCE

Each Department Determines Unique Opportunities and
Methods to Address the Hospital Goals

The Quarterly Report Consists of the Following:



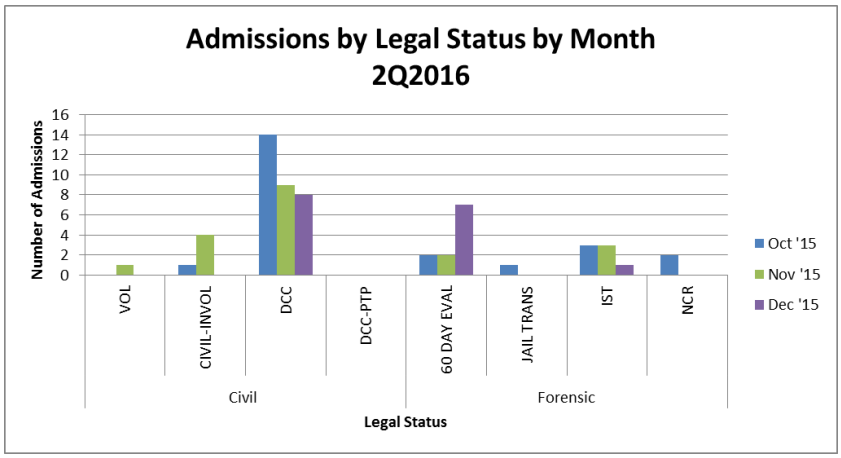
STRATEGIC PERFORMANCE EXCELLENCE

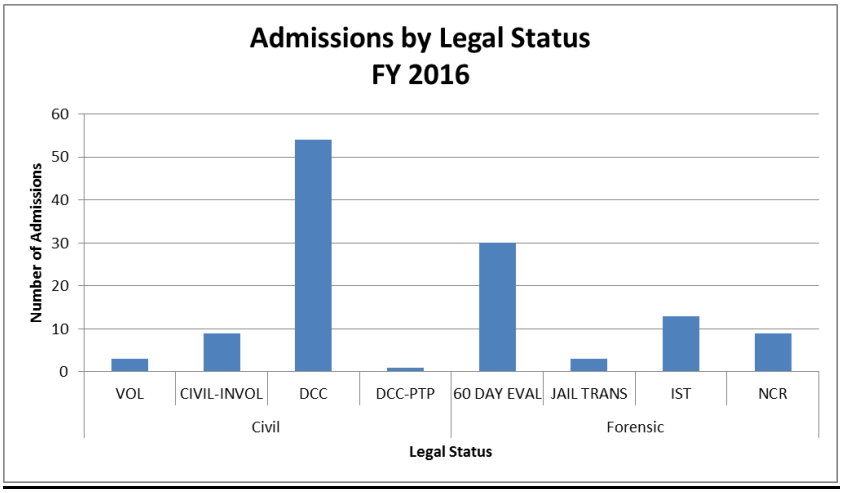
Admissions

Responsible Party: Jamie Meader, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**7**	**13**	**10**	**15**	**14**	**8**							**67**
VOL	0	1	1	0	1	0							**3**
CIVIL-INVOL	0	2	2	1	4	0							**9**
DCC	7	9	7	14	9	8							**54**
DCC-PTP	0	1	0	0	0	0							**1**
FORENSIC:	**10**	**16**	**8**	**8**	**5**	**8**							**55**
60 DAY EVAL	8	8	3	2	2	7							**30**
JAIL TRANS	0	0	2	1	0	0							**3**
IST	0	4	2	3	3	1							**13**
NCR	2	4	1	2	0	0							**9**
TOTAL	**17**	**29**	**18**	**23**	**19**	**16**							**122**



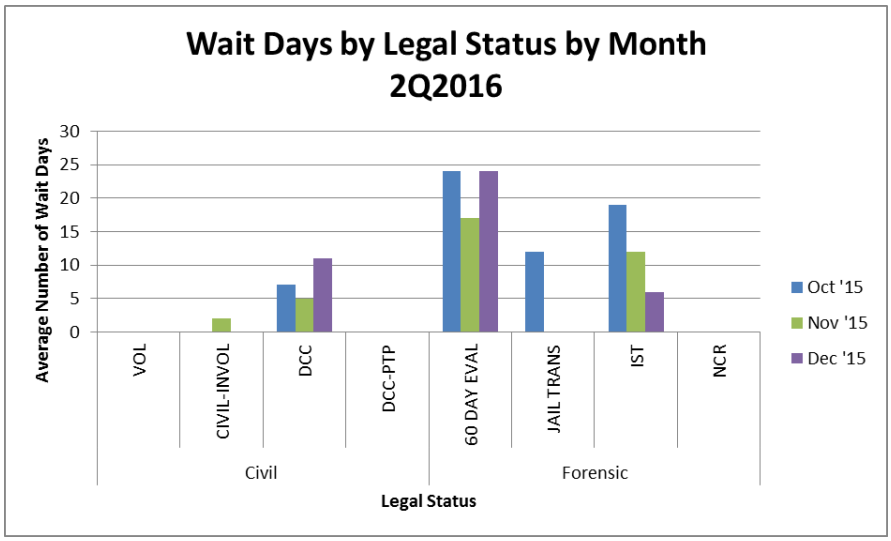


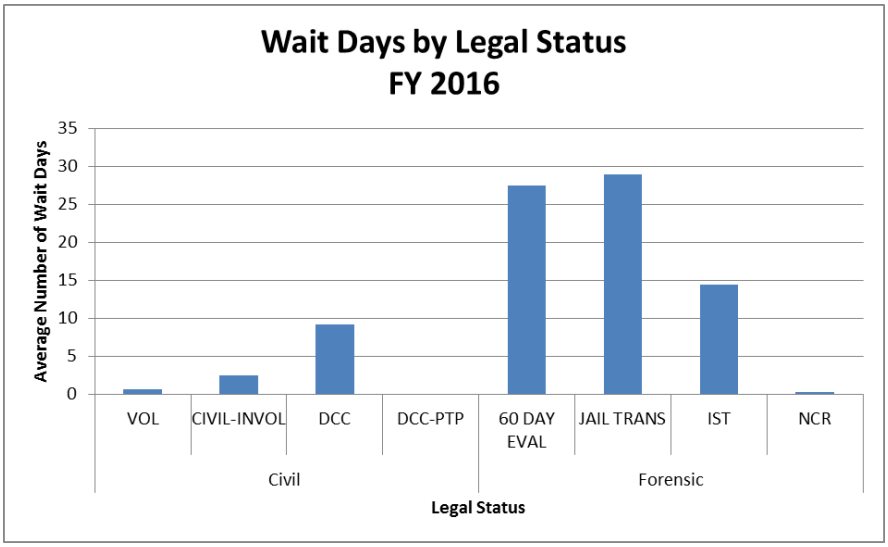
STRATEGIC PERFORMANCE EXCELLENCE

Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**15**	**6**	**8**	**7**	**4**	**11**							**9**
VOL		1	1		0								**1**
CIVIL-INVOL		5	3	0	2								**3**
DCC	15	7	10	7	5	11							**9**
DCC-PTP		0											**0**
FORENSIC:	**53**	**18**	**19**	**15**	**14**	**22**							**24**
60 DAY EVAL	66	25	9	24	17	24							**28**
JAIL TRANS			46	12									**29**
IST		20	15	19	12	6							**14**
NCR	0	0	1	0									**0**
AVERAGE	**37**	**12**	**13**	**10**	**6**	**16**							**16**

*If a field is blank it means that there were no admissions for that legal status and timeframe

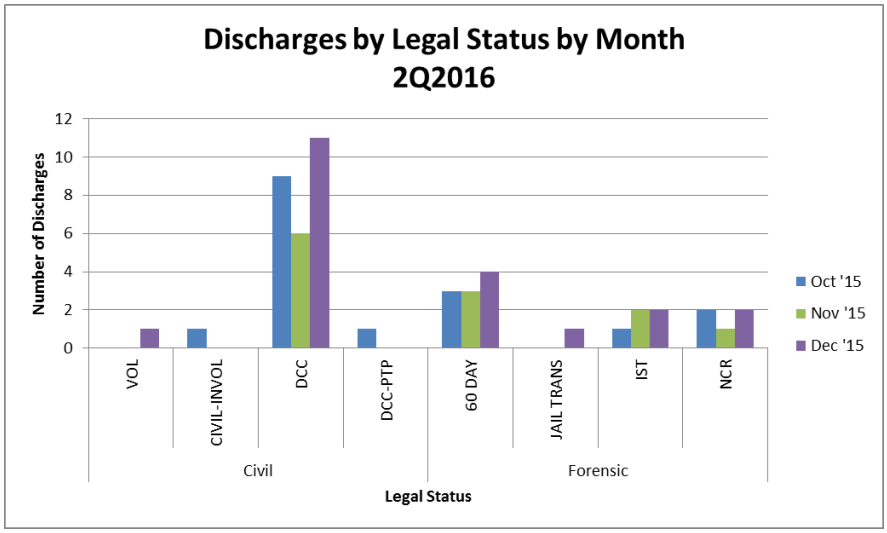


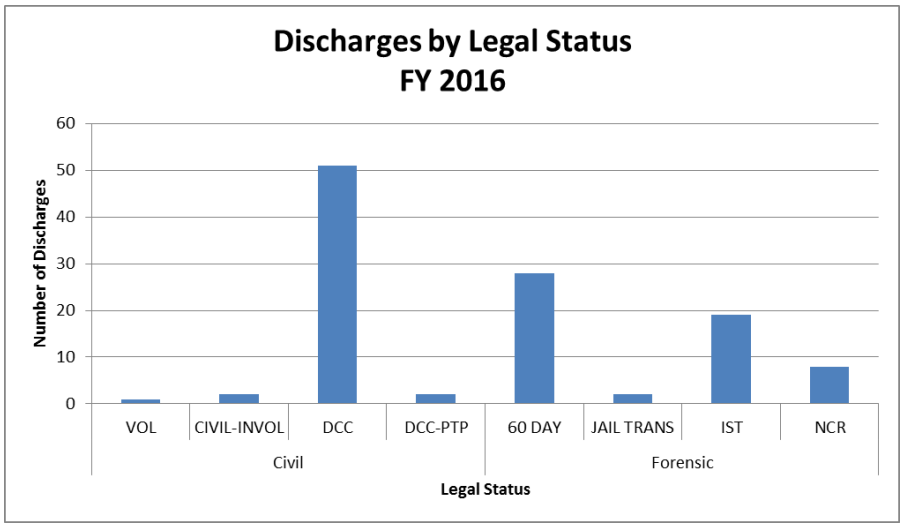


STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**8**	**8**	**11**	**11**	**6**	**12**							**56**
VOL	0	0	0	0	0	1							**1**
CIVIL-INVOL	1	0	0	1	0	0							**2**
DCC	6	8	11	9	6	11							**51**
DCC-PTP	1	0	0	1	0								**2**
FORENSIC:	**10**	**16**	**10**	**6**	**6**	**9**							**57**
60 DAY	3	10	5	3	3	4							**28**
JAIL TRANS	0	0	1	0	0	1							**2**
IST	5	5	4	1	2	2							**19**
NCR	2	1	0	2	1	2							**8**
TOTAL	**18**	**24**	**21**	**17**	**12**	**21**							**113**

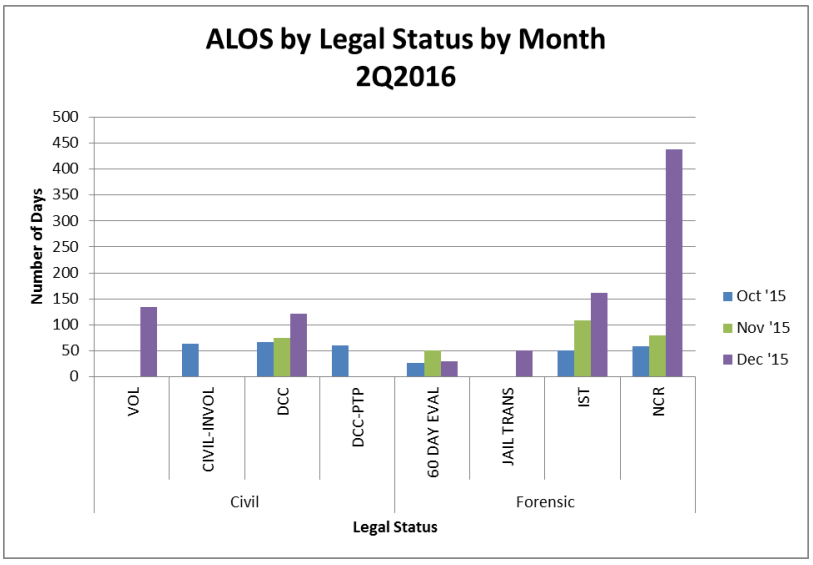


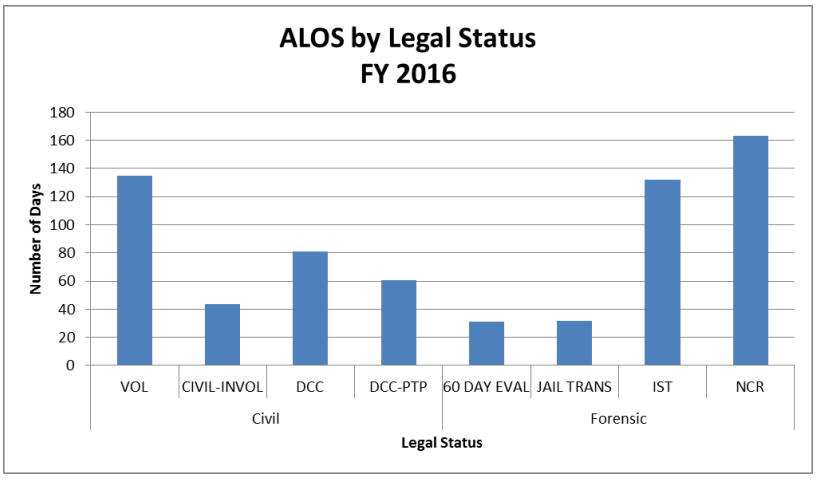


STRATEGIC PERFORMANCE EXCELLENCE

Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**64**	**70**	**83**	**65**	**74**	**122**							**80**
VOL						135							**135**
CIVIL-INVOL	23			64									**44**
DCC	71	70	83	67	74	121							**81**
DCC-PTP	61			60									**61**
FORENSIC:	**118**	**98**	**73**	**41**	**74**	**152**							**93**
60 DAY EVAL	24	27	28	26	50	30							**31**
JAIL TRANS			12			51							**32**
IST	74	252	146	50	108	161							**132**
NCR	371	31	0	59	80	438							**163**
AVERAGE	**94**	**88**	**78**	**57**	**74**	**135**							**88**





STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: NCR Admissions

Measure Description: Admittance of all NCR patients within 24 hours of referral

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	NCR referrals admitted within 24 hours	N/A	100%	100%	100%	100%	**100%**
Actual			86% 6/7	100% 2/2			**89% 8/9**

Data Analysis: Two NCR admissions occurred this quarter and both were admitted on the day of referral.

Action Plan: Continue to gather data on wait days for NCR admissions. Keep one bed available on the Forensic unit for NCR admissions at all times.

Graph/Chart:

	October 2015	**November 2015**	**December 2015**	**2Q2016**
# of NCR Admissions	2	0	0	**2 (Total)**
Wait Days	0	0	0	**0 (Average)**

II. Measure Name: Jail Transfer Bed

Measure Description: Keep one Jail Transfer bed open and track length of stay and legal outcomes.

Type of Measure: Performance Improvement

Data Analysis: One Jail Transfer was admitted this quarter. JTF was admitted in October and waited 12 days for admission. There was a LOS of 51 days (patient was returned to jail and bailed out). JTF admitted from last quarter had charges dismissed and was transferred to the civil side.

Action Plan: Continue to track data and keep one bed available for jail transfers.

Graph/Chart:

	October 2015	November 2015	December 2015	2Q2016 Total
# of Jail Transfer (JTF) Admissions	1	0	0	**1**
# of Jail Transfer (JTF) Discharges	0	0	1	**1**

III. Measure Name: Off Shift PA Admission Paperwork

Measure Description: All required documentation will be complete and accurate for admissions on the off shifts by the PA.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Documentation complete and accurate for admissions on off shifts	N/A	100%	100%	100%	100%	**100%**
Actual			100% 3/3	50% 1/2			**80% 4/5**

Data Analysis: Two off shift admissions occurred this quarter. One admission was completed as policy dictates; the other admission was missing multiple documents. The PA was notified of the missing documentation for follow up.

Action Plan: Continue to monitor data so paperwork is completed accurately and timely.

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Dental Clinic

Responsible Party: Dr. Ingrid Prikryl, Dentist

I. Measure Name: Yearly Periodontal Charting

Measure Description: Complete a full mouth periodontal charting.

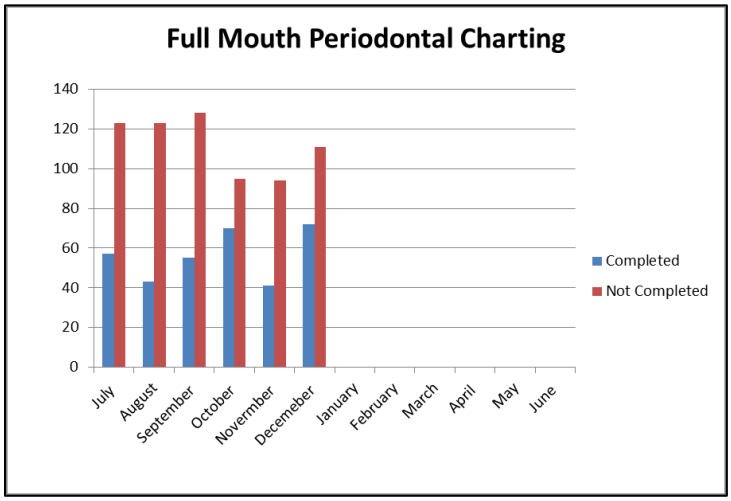
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	% of appointments where full mouth periodontal charting was completed	FY 2015 42%	50%	55%	60%	65%	**75%**
Actual			41%	61%			**50%**

Data Analysis: 2Q2016 periodontal charting increased by 20%.

Action Plan: Charting to be completed by the hygienist during prophy appointments and/or with dentist during exam appointment.

Comments: Target is to be at 60% by the next six month recall cycle and then at 75% after 12 month recall. This is a challenge because not all patients are able and/or willing to sit for periodontal charting.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Improving Oral Hygiene

Measure Description: Monitoring patients' oral hygiene and working to improve it

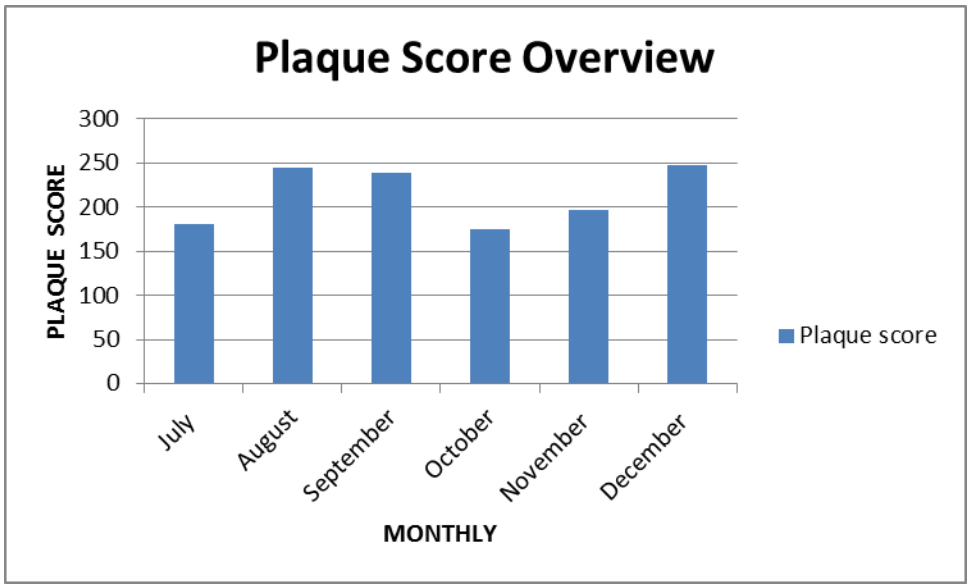
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Plaque Score Monthly	Fair 213.25	Fair (220-16)	Fair (220-16)			
Actual			Poor 221	Fair 207			**Fair 214**

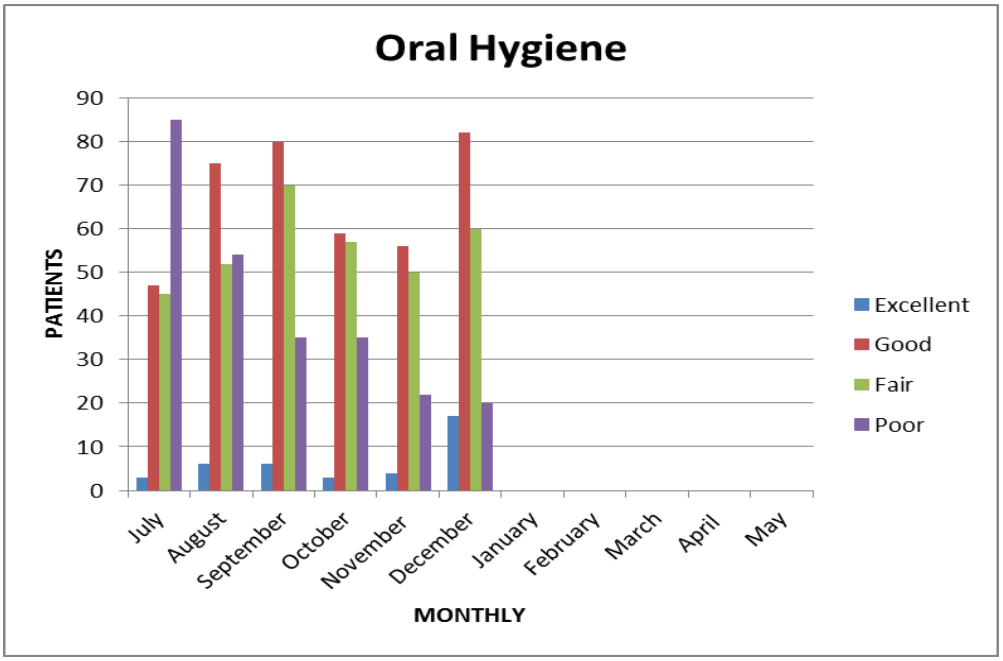
Data Analysis: Smaller numbers demonstrate less plaque on our patients' teeth, therefore improved oral hygiene.

Action Plan: Plaque scores should increase in a 6 month cycle with proper oral hygiene instructions.

Comments: We are working to educate our patients on brushing daily and its importance for proper oral care and retention of teeth.



STRATEGIC PERFORMANCE EXCELLENCE



III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

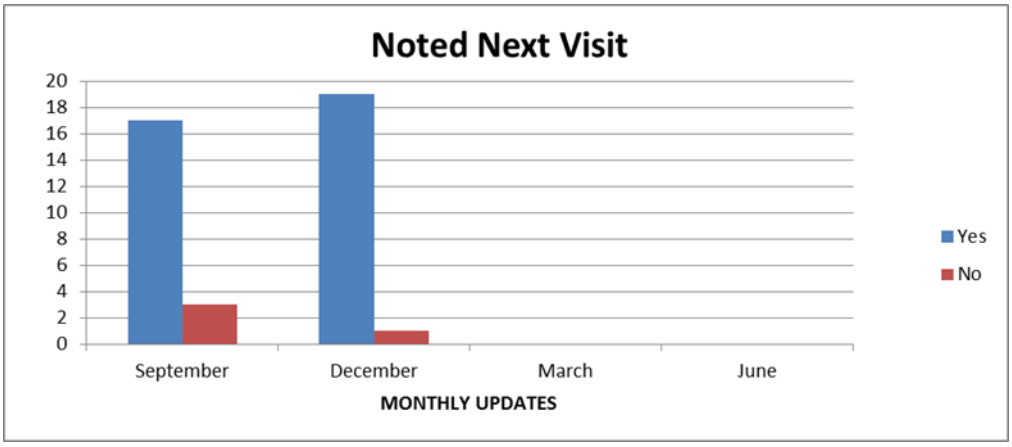
Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	# of progress notes with next visit documented	66% FY 2015	70%	75%	80%	85%	**90%**
Actual			60%	95%			**90%**

Data Analysis: FY2015 YTD was 66%; therefore, it has become a performance improvement measure. we would like this measure to be at 90 – 100%. We had a 35% increase from 1Q2016 to 2Q2016.

Action Plan: Write at the end of every progress note what the next visit is going to be even if it is a 3 MRC or denture adjustment as needed. Random weekly checks on most recent progress note will be measured on daily tally sheet.

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Medication Management Clinic

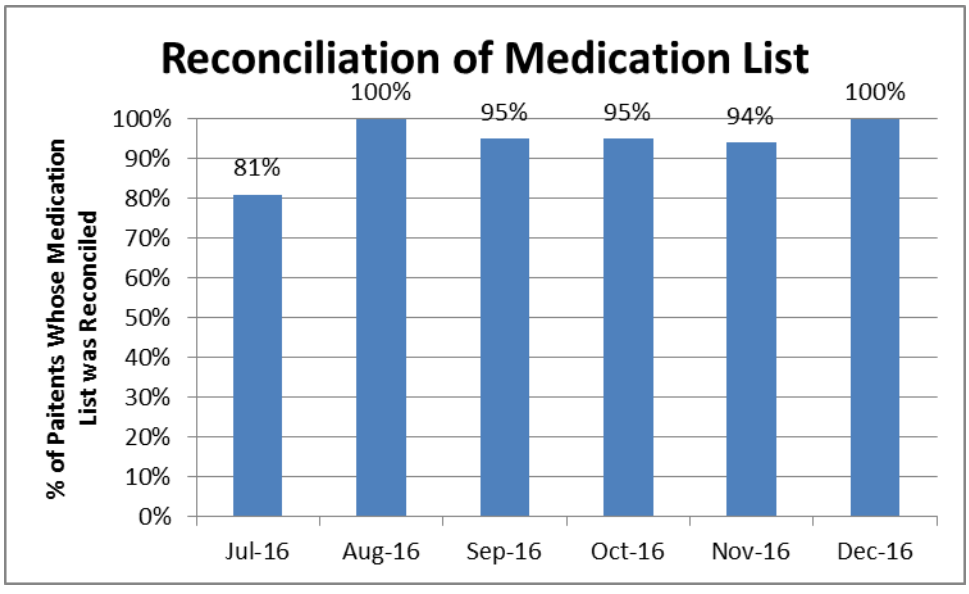
Responsible Party: Robin Weeks, Medical Assistant

I. Measure Name: Reconciliation of Outpatient Medication List

Measure Description: Each visit will cover reconciliation of medical & psychotropic medications with patients.

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Reconciliation completed per visit.	FY15 Q2 73%	100%	100%	100%	100%	**100%**
Actual			85% 46/54	100% 59/59	94% 59/63	97% 57/59	**94% 221/235**



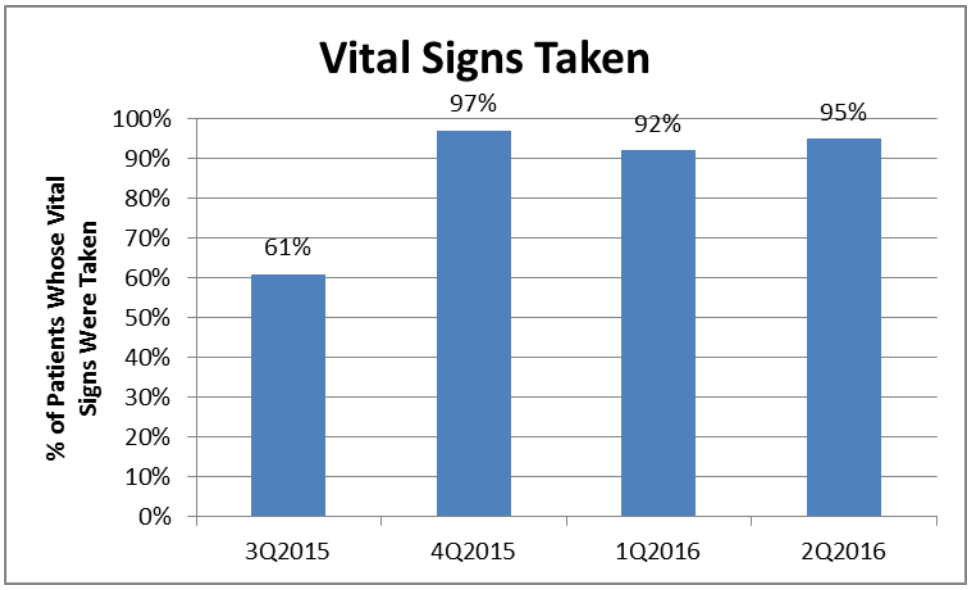
STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vital Signs

Measure Description: Taking vital signs each visit will give us an idea of the effects of the prescribed medications and early detection of possible medical problems with the patient.

Measure Type: Quality Improvement

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Reconciliation completed per visit.	FY15 Q1 73%	100%	100%	100%	100%	**100%**
Actual			61% 28/46	97% 57/59	92% 58/63	95% 56/59	**82% 199/227**



STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela, Dietetic Services Manager

I. Measure Name: Nutrition Screen Completion

Measure Description: The Registered Dietitian will review each patient's Nursing Admission Data to assess ongoing compliance with the completion of the Nutrition Screen tool; within 24 hours of admission.

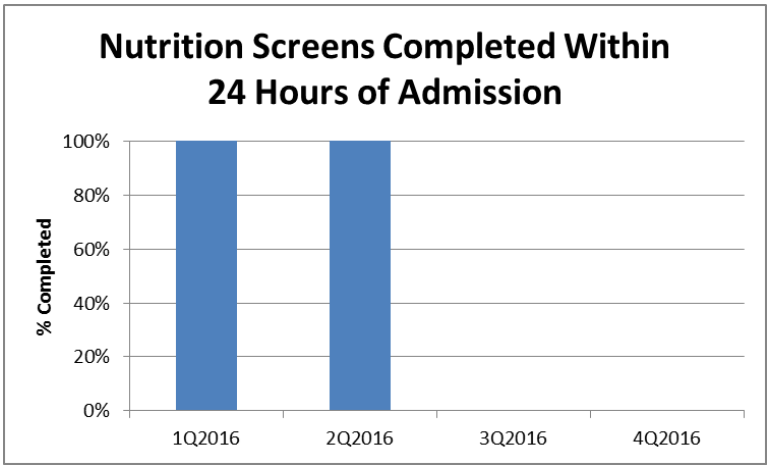
Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed on time	FY 2015 95%	95%	95%	95%	95%	**95%**
Actual			100% 60/60	100% 61/61			**100% 121/121**

Data Analysis: Completion of the nutrition screens within 24 hours of admission has remained above target levels. This monitor began as an indicator in FY 2013.

Action Plan: To assure optimum care for our patients, this monitor will remain a quality assurance measure. As a follow up to this measure, there has been a performance improvement monitor developed to evaluate the accuracy of the screens being completed.

Comments: This is a multidisciplinary measure that has proven successful.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Nutrition Screen Accuracy

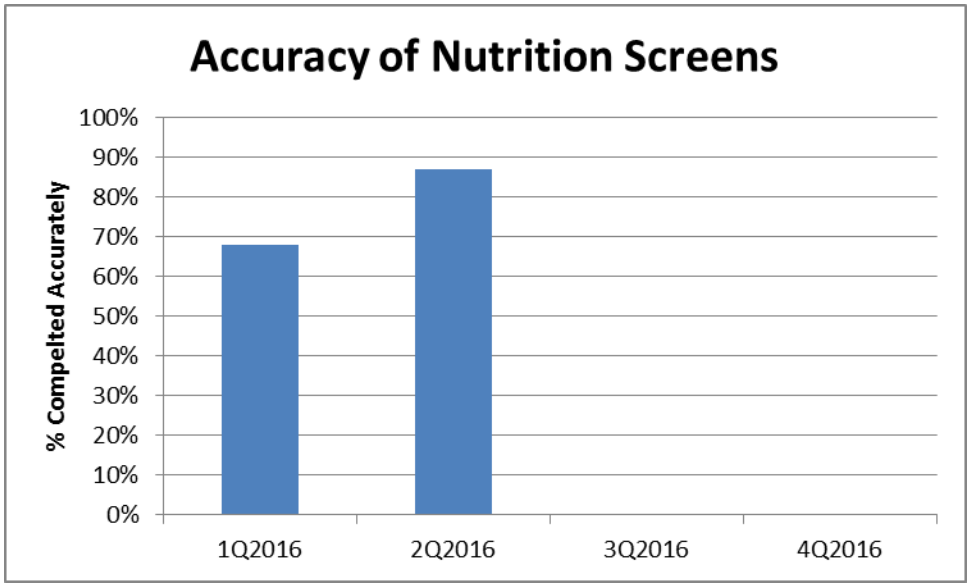
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data, upon admission, to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY 2016 Q1 68% 41/60	Baseline established	95%			**95%**
Actual			68% 41/60	87% 53/61			**78% 94/121**

Data Analysis: These results indicate there has been an 18.7% improvement in the accuracy of the information gathered on the nutrition screen. The nutrition screen is completed by the nurse responsible for the admission. The diagnosis on the nutrition screen that is commonly not identified is the "BMI>29"; 7 of the 8 errors. Additionally, seven of the eight errors were documented by the same admitting nurse.

Action Plan: Meet with the admitting nurse responsible for this data collection to determine if there is a barrier or misinterpretation of the requirements for completing the screening.



STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Hand Hygiene Compliance

Measure Description: Supervisory staff: including the Food Service Manager and Cook III's, will observe all dietary employees, as they return from break, for proper hand hygiene.

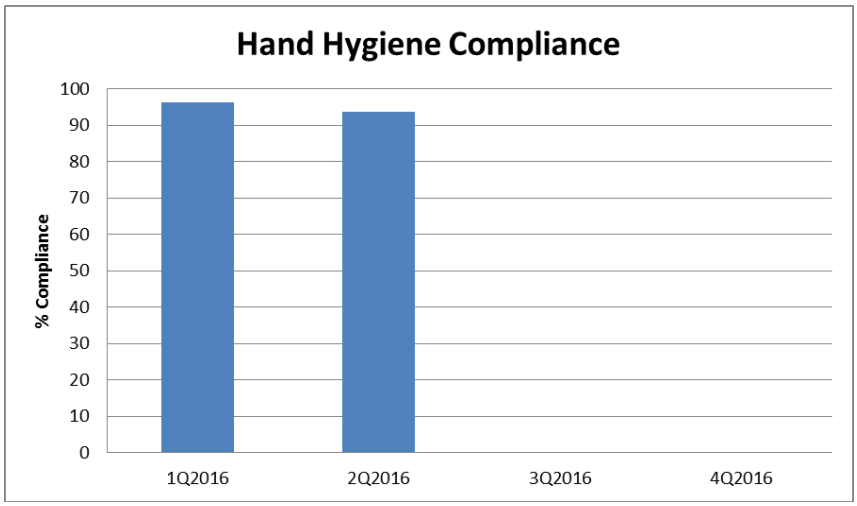
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Dietary employees washing hands after break	FY 2015 98% 338/346	90%	95%			**93%**
Actual			96% 343/356	94% 215/229			**93% 558/585**

Data Analysis: The results of this quarter remain above 90%. There was a 2.5% decrease in compliance. Total observations decreased by 127. Two employees accounted for eight of the fourteen times that handwashing wasn't observed. Seven additional employees weren't observed washing their hands once within this rating period.

Action Plan:

- Continue to have front line supervisors monitor handwashing compliance after breaks.
- Provide hand hygiene training annually and review techniques with staff not in compliance.
- Encourage front line supervisors to promote hand hygiene with their staff throughout the day.



STRATEGIC PERFORMANCE EXCELLENCE

Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

I. Measure Name: Communications Equipment/Two-way radios

Measure Description: The Joint Commission states the following in EM.02.02.01: "As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies. *The hospital maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations."*

In the event of an unforeseen emergency which could impact the safety and security of patients, staff, and visitors, communications equipment, more specifically, two-way radios are a major solution to getting accurate information to and from staff in a timely manner. The objective of the Emergency Management Communications PI is to ensure compliance with The Joint Commission standard with the overall objective of ensuring that the two-way radio system is fully functional and that staff are proficient in its use.

Type of Measure: Performance Improvement

Methodology: Each month, the Emergency Management Coordinator or designee will perform a combination of partial and hospital-wide radio drills. Such drills will utilize a specific form to track the drills (see attached). In conjunction with the drills, environmental rounds will be conducted for the purpose of inspecting communications equipment. Any deficiencies shall have the appropriate corrective measure immediately instituted until compliance is met.

The numerator is the number of timely and appropriate responses by staff utilizing the two-way radios by assignments. The denominator will be the total number of two-way radios by assignments.

Baseline Data: To assure that critical emergency information is disseminated in a timely and accurate manner, **a minimum of 90%** compliance has been established. This data will be reported monthly to the Emergency Management Committee, IPEC, and the Environment of Care (EOC) Committee. Areas that fail to meet the threshold will be immediately reported to the aforementioned committees.

STRATEGIC PERFORMANCE EXCELLENCE

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90%	90%			**90%**
Actual			92% 147/159	96% 153/159			**94% 300/318**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that staff has become very familiar with operating the radio. Although the actual percentage of timely and appropriate responses has increased, the critical components such as having alert notification equipment in ready order needs improvement. We continue to investigate the most appropriate equipment that is not so dependent on staff oversight.

Action Plan:

1. Continued tests and remedial training to staff along with supporting handouts as needed.
2. Increased surveillance of mass notification equipment such as alert pagers.
3. Investigate various media to notify staff to employ radios.

Comments: 96% of assigned radio equipment is placed into service in a timely manner. Although this response adequately assures that the majority of occupants will receive timely and critical information, it still leaves a small population of staff who could be in harm's way if they do not receive critical information through mass notification.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

Areas/Groups Monitored N = Numerator D = Denominator	JUL 2015	AUG 2015	SEPT 2015	OCT 2015	NOV 2015	DEC 2015	JAN 2016	FEB 2016	MAR 2016	APR 2016	MAY 2016	JUNE 2016	JULY 2016
Patient Care Areas/ # of radios													
Job Coach/1	1/ 1*	1/ 1	1/ 1*	1/ 1	1/ 1*	0/ 1**							
OPS/2	2/ 2*	2/2	1/ 2*1	2/ 2	2/ 2*	2/2							
Tx Mall, Clinic, Dietary, Med Rec/5	5/ 5*	5/ 5	3/ 5*2	5/ 5	5/ 5*	4/ 5*5							
US, UK, LS, LSSCU, LK, LKSCU/10	9/ 10	10/ 10	8/ 10*3	10/ 10	7/ 10*3	9/ 10							
Support Services/ # of radios													
Administration/3	3/ 3*	3/ 3	3/ 3	3/ 3	3/ 3*	3/ 3							
Housekeeping/ 10	9/ 10**	10/ 10	9/ 10*3	9/ 10*1	10/ 10*	10/ 10							
Maintenance/14	14/ 14*	14/ 14	12/ 14*4	14/ 14	14/ 14*	14/ 14							
NOD/1	1/1	1/1	1/1	1/1	0/ 1*4	1/ 1*							
Nursing Services/1	1/ 1*	1/ 1	0/ 1*5	0/ 1*2	1/ 1*	0/ 1*6							
Operations/1	1/1	1/1	1/1	1/1	1/1	1/1							
Security/4	4/4	4/4	4/4	4/4	4/4	4/4							
State Forensic Services/1	1/ 1*	1/ 1	0/ 1*6	1/ 1	1/ 1*	0/ 1*7							
Patient Care Areas	**17/ 18**	**18/ 18**	**13/ 18**	**18/ 18**	**15/ 18**	**18/ 18**							
Support Services	**34/ 35**	**32/ 35**	**30/ 35**	**33/ 35**	**34/ 35**	**32/ 35**							
Total	**51/ 53**	**53/ 53**	**43/ 53**	**51/ 53**	**49/ 53**	**53/ 53**							

STRATEGIC PERFORMANCE EXCELLENCE

Key:

*Radio units not on duty due to shift assignment therefore given same weight in order not to have a negative impact. EMC: Emergency Management Coordinator

*1 Did not hear test due to radio being turned down. Remedial training held for staff.

*2 General staff in area were not aware that radio was assigned to that location. EMC educated staff.

*3 Operations had to call (2) units. Staff did not respond to the Code Triage.

*4 Staff called Operations requesting the definition of "Code Triage". Upon further examination, the radio was dead. Not placed in charger properly. EMC educated staff.

*5 Operations called unit since staff did not respond to the "Code Triage". Pager for alert had a dead battery. EMC educated staff. Battery replaced.

*6 Operations had to call unit since staff did not respond to the "Code Triage". No means to receive message. Pager issued to Secretary. EMC educated staff.

*7 Operations had to call unit. Department Director was the only person in office. EMC to provide remedial training as requested.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Rebecca Eastman, RN

I. Measure: Harbor Mall Hand-Off Communication

Objectives	3Q 2015	4Q 2015	1Q 2016	2Q 2016	Total FY2016
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	86% 36/42	76% 32/42	79% 44/56	93% 39/42	**83% 151/182**
2. SBAR information completed from the units to the Harbor Mall.	86% 36/42	74% 31/42	79% 44/56	93% 39/42	**83% 150/182**

Define: To provide the exchange of patient-specific information between the patient care units and the Harbor Mall for the purpose of ensuring continuity of care and safety within designated time frames.

Measure: 71% for July, 86% for August, 93% for September, 79% for October, 100% for November, and 100% for December. Measure increased from 79% in 1Q2016 to 93% in 2Q2016.

Analyze: For October there was one sheet that was not turned in. For November the specific time frame for being late was five minutes. For December the specific time frame for being late was four minutes. We will continue to concentrate on both indicators to maintain current performance.

Improve: We will review the results of this report with the RN IV's from each unit. We will also review the data for HOC sheets that did not arrive at the mall within the designated time frame from the units. We added a statement at the bottom of the sheet reminding them to be turned in by ten minutes after the hour so the leaders know if there are any issues with the patients and it is highlighted in yellow.

Control: To continue to monitor the data and follow up with any unit(s) that may be having difficulties in developing or maintaining a process to meet the objectives above.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Michelle Welch, RHIT

Documentation and Timeliness:

Indicators	2Q2016 Findings	2Q2016 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	49 charts for patients released during the quarter were samples. 100% of the charts were completed within the required timeframe.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	47 of the 49 discharge summaries were completed within 15 days of discharge.	96%	100%
Medical transcription will be timely and accurate.	Out of requested dictated reports, all were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 100% compliance with 30 day record completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Clinical Director, along with the Superintendent, Risk Manager and the Director of Integrated Quality and Informatics. There was 100% compliance with timely & accurate medical transcription services.

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Confidentiality:

Indicators	2Q2016 Findings	2Q2016 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	1822 requests for information (157 requests for patient information and 1665 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	All new employees/contract staff attended confidentiality/HIPAA training.	100%	100%
Confidentiality/privacy issues tracked through incident reports.	0 privacy-related incident reports.		

Summary: The indicators are based on the review of all requests for information, orientation for all new employees/contract staff and confidentiality/privacy-related incident reports.

No problems were found in 2Q2016 related to release of information from the Health Information Department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions: The above indicators will continue to be monitored.

STRATEGIC PERFORMANCE EXCELLENCE

Release of Information for Concealed Carry Permits:

Define:
The process of conducting background checks on applicants for concealed carry permits is the responsibility of the two State psychiatric hospitals. Patients admitted to private psychiatric hospitals, voluntarily or by court order, are not subject to this review. Delays in the processing of background checks has become problematic due to an increasing volume of applications and complaints received regarding delays in the processing of these requests

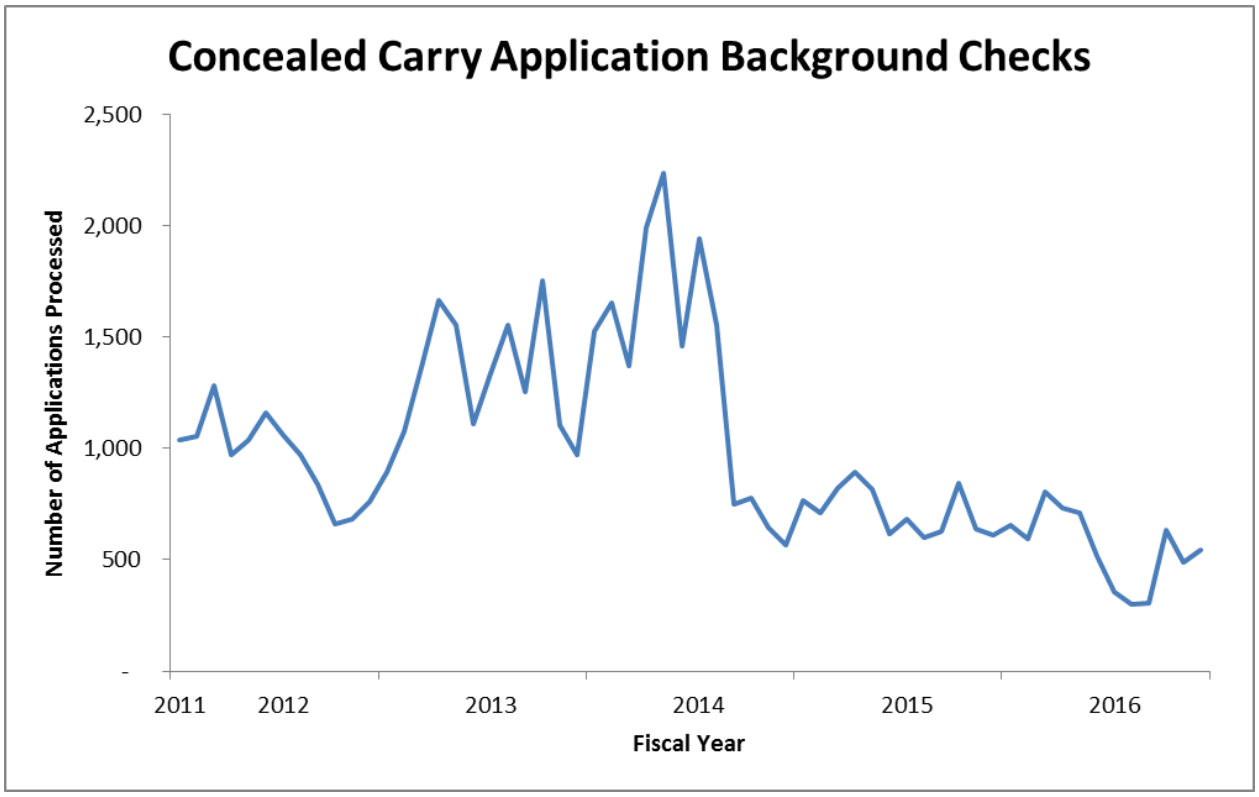
Analyze:
Data collected for the 2Q2016 showed that we received 1665 applications. This is an increase from last quarter 1Q2016 when we received 959 applications.

Improve:
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. OIT has also created a new patient index in which we are in the process of consolidating sources we search into this one system. Over time this will decrease time spent searching as we will no longer have to search several sources. This is ongoing.

Note: In July 2015, a new State of Maine law was approved effective October 2015. This law no longer requires citizens to have a concealed carry permit to carry a concealed weapon within the State of Maine. However, if citizens want to carry concealed outside Maine they will still need to apply for a concealed carry permit. We expect this to decrease the number of concealed carry permit applications we receive and process.

Year	FY 2015						FY2016						Total
Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
# Applications Received	655	594	806	732	713	516	353	302	304	634	489	542	6640

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

I. Measure Name: Patient Living Area

The Housekeeping Department will maintain an acceptable standard of cleanliness and sanitation in patient living areas.

Measure Description: The Housekeeping Supervisor or designee will perform a monthly inspection of the patient living area and record the findings on the Housekeeping Inspection Form. Any unit not meeting the threshold will be inspected every two weeks until compliance is met

Method of Monitoring: Inspection scores will be summarized monthly. Patient areas that fail to meet the threshold will be reported to the IPEC group, EOC, and the Director of Support Services. This report will include any actions taken.

Results:

Unit	Target	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Lower Saco	85%	91%	89%	94%		**90%**
Upper Saco	85%	88%	87%	88%		**87%**
Lower Kennebec	85%	85%	89%	90%		**87%**
Upper Kennebec	85%	90%	87%	89%		**88%**
Overall Average	**85%**	**89%**	**88%**	**90%**		**88%**

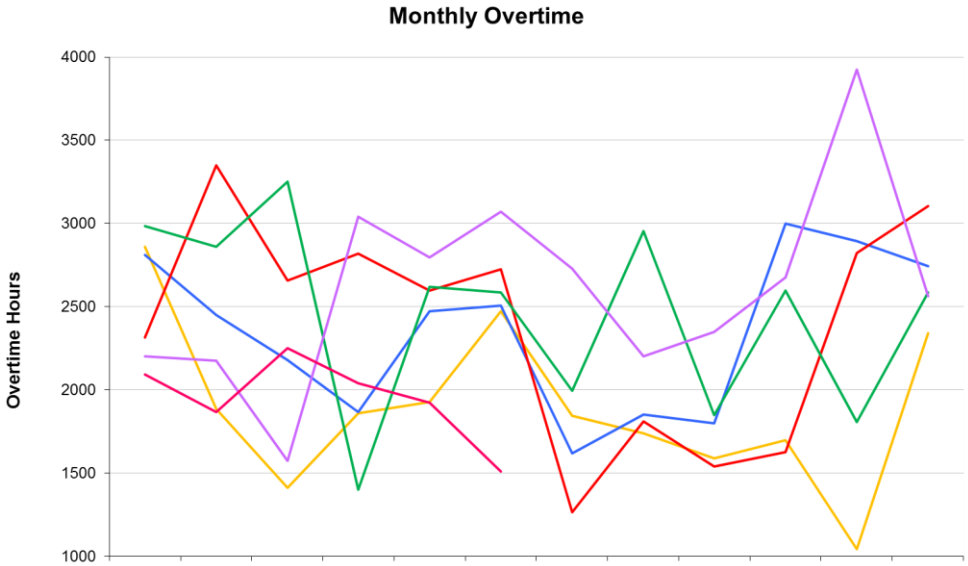
Data Analysis: The Housekeeping Supervisor inspected units monthly and found that window cleaning, water cooler cleaning and floor care in the nurses station were consistent problem areas.

Action Plan: The Housekeeping Supervisor will continue to do weekly inspections to assure that cleanliness of the environment continues to improve.

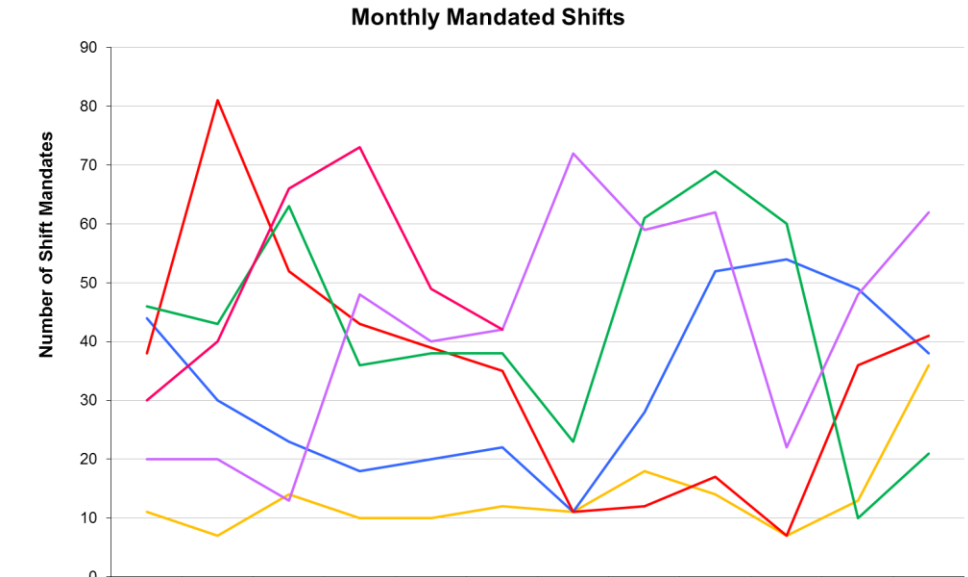
STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400	2620	2586	1994	2954	1848	2599	1806	2586
FY 2015	2204	2177	1575	3040	2797	3070	2729	2203	2351	2677	3927	2562
FY 2016	2095	1868	2250	2041	1923	1512						



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	63	36	38	38	23	61	69	60	10	21
FY 2015	20	20	13	48	40	42	72	59	62	22	48	62
FY 2016	30	40	66	73	49	42						

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: License Reviews

Measure Description: Ensuring that licenses/registry entries are verified via the appropriate source prior to hire for all licensed (or potentially licensed) new hires.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percentage Licenses Reviewed	FY 2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 19/19	100% 6/6			**100% 25/25**

Data Analysis: During 2Q2016, there were 8 new hires. Of those, 6 were licensed, or potentially licensed. License and CNA Registry checks were performed prior to hire on all 6.

Action Plan: No action is needed at this time.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Responsible Party: Dr. Brendan Kirby, Clinical Director

Quality Improvement Plan
2015-2016

As specified in Article Seven of the Medical Staff Bylaws, the improvement and assurance of medical staff quality and performance is of paramount importance to the hospital. This plan insures that the standards of patient care are consistent across all clinical services and all specialties and categories of responsible practitioners. Through a combination of internal and external peer review, indicator monitoring, focused case reviews of adverse outcomes or sentinel events, routine case reviews of patients with less than optimal outcomes, and the establishment of performance improvement teams when clinical process problems arise, the medical staff will insure quality surveillance and intervention activities appropriate to the volume and complexity of Riverview's clinical workload. Medical Staff Quality Improvement efforts will be fully integrated with the hospital-wide Integrated Performance Excellence Committee (IPEC) so that information can be sent to and received from other clinical and administrative units of the hospital. The Clinical Director, assisted by the President of the Medical Staff, will serve as the primary liaison between the MEC and IPEC. Oversight of the Medical Staff Performance Improvement Plan is primarily delegated to the Clinical Director in conjunction with the President of the Medical Staff, the Director of Integrated Quality and Informatics, the Superintendent, and ultimately to the Advisory Board.

The goal of the Medical Staff Quality Improvement Plan is to provide care that is:

Safe
Effective
Patient centered
Timely
Efficient
Equitable
Designed to improve clinical outcomes

To achieve this goal, medical staff members will participate in ongoing and systematic performance improvement efforts. The performance improvement efforts will focus on direct patient care processes and support processes that promote optimal patient outcomes. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other appropriate quality improvement techniques.

STRATEGIC PERFORMANCE EXCELLENCE

1. **Peer Review Activities**:

   a. Regularly scheduled internal peer review by full time medical staff occurs on a monthly basis at the Peer Review and Quality Assurance Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including nursing, administration, the risk manager, or the Clinical Director), and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case monthly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered. In addition all medical staff members (full and part-time) will have a minimum of one chart every other month peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

   b. Special internal peer review or focused review. At the direction of the Clinical Director a peer chart review is ordered for any significant adverse clinical event or significant unexpected variance. Examples would be a death, seclusion or restraint of one patient for eight or more continuous hours, patient elopement, the prescribing of three or more atypical antipsychotics for the same patient at the same time, or significant patient injury attributable to a medical intervention or error.

   c. External peer review occurs regularly through contracts with the Maine Medical Association and the Community Dental Clinic program. We plan to continue our recent tradition of a biannual assessment of the psychiatry service and the medical service by peers in those clinical areas based on random record assessment of 25 cases in each service. An outside dentist from Community Dental will also review 20 charts of the hospital dentist for clinical appropriateness at least annually. Our contract with the Maine Medical Association also allows for special focused peer reviews of any unexpected death or when there is a question of a significant departure from the standard of care.

2. **MEC Subcommittee and IPEC Indicator Monitoring Activities**:
The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:
   a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
      - Psychiatric Emergencies
      - Seclusion and Restraint Events
      - Staff or Patient Injuries
      - Priority I Incident Reports
      - Other clinical/administrative department monitoring activity
   b. Pharmacy and Therapeutics Committee:
      - Medication Errors Including Unapproved abbreviations
      - Adverse Drug Reactions
      - Pharmacy Interventions
      - Antibiotic Monitoring
      - Medication Use Evaluations
      - Psychiatric Emergency process
   c. Medical Records Committee:
      - Chart Completion Rate/Delinquencies
      - Clinical Pertinence of Documentation of Closed Records
   d. Infection Control Committee:
      - Infection Rates (hospital acquired and community acquired)
      - Staff Vaccination Rates/Titers
   e. Utilization Management Committee:
      - Admission Denials
      - Timeliness of Discharges After Denials
   f. Peer Review and Quality Assurance Committee:
      - Hospital-wide Core Measures and NASMHPD Data
      - Patient Satisfaction Surveys
      - Administrative concerns about quality
      - Special quality improvement monitors for the current year (see also the Appendix and number 6 below).
      - Reports from the Human Rights Committee regarding patient rights and safety issues
      - Specific case reviews

3. **Performance or Process Improvement Teams**:
When requested by or initiated by other disciplines or by hospital administration, or when performance issues are identified by the medical staff itself during its monitoring activities, the Clinical Director will appoint a medical staff member to an ad hoc performance improvement team. This is generally a multidisciplinary team looking at ways to improve hospital wide processes. Currently the following performance improvement teams involving medical staff are in existence or have recently completed their reviews:
    a. Review of treatment plans
    b. Lower Saco Unit

4. **Miscellaneous Performance Improvement Activities**:
In addition to the formal monitoring and peer review activities described above, the Clinical Director is vigilant for methods to improve the delivery of clinical care in the hospital from interactions with, and feedback from, other discipline chiefs, from patients or from their complaints and grievances, and from community practitioners who interact with hospital medical staff. These interactions may result in reports to the Medical Executive Committee, in the creation of performance improvement teams, performance of a root-cause analysis, or counseling of individual practitioners.

5. **Reports of Practitioner-specific Data to Individual Practitioners**:
The office of the Clinical Director will provide confidential outcomes of practitioner-specific data to each medical staff member within 30 days of the end of the fiscal year. This information will be available without the necessity of the practitioner requesting it. It will be placed in the confidential section of the practitioner's medical staff file and freely accessible during normal business hours. The office of the Clinical Director will notify all medical staff members when the data is available for review. Each medical staff member may discuss the data with the Clinical Director at any time.

6. **Process to amend the quality improvement plan, including adding or deleting any monitors or processes:**
Upon the recommendation of the Clinical Director, upon recommendation of the MEC as a whole after a request from any member of the medical staff, from a recommendation of the Integrated Performance Excellence Committee, or upon recommendation of the Advisory Board, this plan may be amended with appropriate approvals at any time. Examples of when amendments might be necessary are the detection of new clinical problems requiring monitoring or when it is discovered that current monitors are consistently at or near target thresholds for six consecutive months. Should the number of active clinical monitors fall below four at any time, replacement monitors will be activated within two months of termination of the previous monitor (s). The Clinical Director, the Medical Staff President, and the MEC are jointly responsible for maintaining an active monitoring system at all times and to

insure that all relevant clinical service areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

Quality Improvement Reporting Schedule to Medical Executive Committee

Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bimonthly
QA/PI/Peer Review Committee	Clinical Director reports monthly and to Individual practitioners as necessary
Research Committee	Clinical Director reports bimonthly
CME Committee	Chair reports bimonthly
Human Rights Committee (Allegations of Abuse, Neglect, and Exploitation)	Clinical Director reports monthly

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: Polyantipsychotic Therapy

Measure Description: The use of two or more antipsychotic medications (polyantipsychotic therapy) is discouraged as current evidence suggests little to no added benefit with an increase in adverse effects when more than one antipsychotic is used. The Joint Commission Core (TJC) Measure HBIPS-5 requires that justification be provided when more than one antipsychotic is used. Three appropriate justifications are recognized: 1) Failure of 3 adequate monotherapy trials, 2) Plan to taper to monotherapy (cross taper) and 3) Augmentation of clozapine therapy. This measure aligns itself with the HBIPS-5 core measure and requires the attending psychiatrist to provide justification for using more than one antipsychotic. In addition to the justification, the clinical/pharmacological appropriateness is also evaluated.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Justified Polyantipsychotic Therapy	85% (2015)	90%	90%	90%	90%	**90%**
Actual			93%	63%	77%	69%	**76%**

Data Analysis: All medication profiles in the hospital are reviewed in each month of the quarter for antipsychotic medication orders. Attending psychiatrists are required to complete a Polyantipsychotic Therapy Justification Form when a patient is prescribed more than one antipsychotic. The percentage of justified polyantipsychotic therapy amongst those patients prescribed two or more antipsychotics is reported here. This quarter we regained round in the number of patients on justifiable polyantipsychotic therapy. An analysis of the patients on polyantipsychotic therapy yielded the following results: One patient was discharged on two antipsychotics without justification for the polyantipsychotic therapy, although the combination was pharmacologically rational. During the past quarter, 22 inpatients were prescribed two scheduled antipsychotics which is lower than last quarter. Ten of the 22 patients do not have justification for the polyantipsychotic therapy, though 7 of those regimens are pharmacologically rational. There are 30 inpatients currently prescribed 2 antipsychotics; one scheduled and one PRN (as needed); all of these regimens are deemed pharmacologically rational.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: This monitor was moved to Quality Assurance at the end of the second quarter. We will continue to monitor for appropriate justification of polyantipsychotic therapy. With the reorganization of the polyantipsychotic documentation process, numbers have improved from last quarter. Pharmacy has resumed alerting providers to provide justifications implementing some which may be partially responsible for this improvement as well.

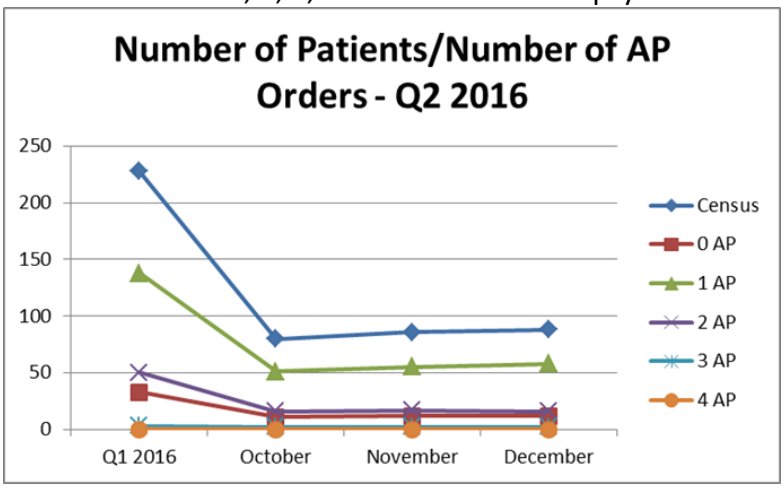
Comments: This quarter saw an improvement in the number of patients on polyantipsychotic therapy but not an increase in documentation of justification for polyantipsychotic therapy. With the new staff becoming more familiar with the process as well as a transition from paper documentation sheets to an excel database, continued improvement is expected.

Graph/Chart:

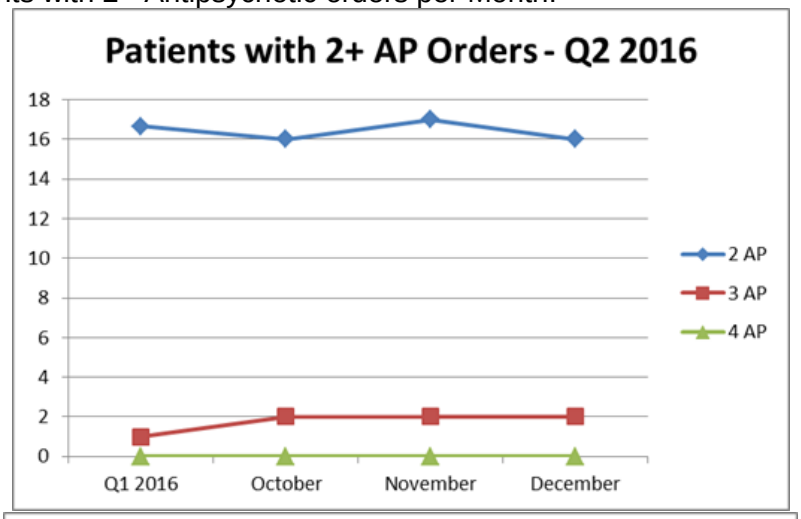
Q2 2016 Report	Q1 2016		October		November		December	
Census	225		80		86		88	
Antipsychotic Orders for Clients	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
No Antipsychotics	34	15	11	14	12	14	12	14
Mono-antipsychotic therapy	143	64	51	64	55	64	58	66
Two Antipsychotics	48	21	16	20	17	20	16	18
Three Antipsychotics	3	1	2	3	2	2	2	2
Four Antipsychotics	0	0	0	0	0	0	0	0
At least 1 antipsychotic	188	84	69	86	74	86	74	84
Total on Poly-antipsychotic therapy	51	23	18	23	19	22	18	20
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics		27% (51/188)		26% (18/69)		26% (19/74)		20.45% (18/88)
More than 2 antipsychotics	3	1.60%	2	0	2	3%		2.27%
Poly-Antipsychotic therapy breakdown	*N*	*%*	*N*	*%*	*N*	*%*		*%*
SGA + FGA	22	43	8	44	7	37	5	28
2 SGAs ("Pine" + "Done")	7	14	0	0	2	11	1	6
Other (2 antipsychotic regimens)	20	39	10	56	7	37	5	28
Details	1) Clozapine + Olanzapine (x3)		1) Clozapine + Olanzapine		1) Aripiprazole + Quetiapine		1) Aripiprazole + Olanzapine	
	2) Olanzapine + Quetiapine		2) Quetiapine + Aripiprazole (x2)		2) Aripiprazole + Olanzapine		2) Quetiapine + Olanzapine (x2)	
	3) Asenapine + Olanzapine		3) Risperidone + Aripiprazole		3) Paliperidone + Aripiprazole		3) Clozapine + Olanzapine (x5)	
	4) Aripiprazole + Paliperidone		4) Aripiprazole + Olanzapine		4) Clozapine + Olanzapine (x4)		4) Aripiprazole + Quetiapine	
	5) Aripiprazole + Quetiapine		5) Aripiprazole + Paliperidone		5) Clozapine + Quetiapine		5) Aripiprazole + Paliperidone	
	6) Clozapine + Quetiapine							
	7) Paliperidone + Ziprasidone							
	8) Aripiprazole + Olanzapine							
3+ Antipsychotic Regimens	3	1.60%	2	11%	2	3%	2	11
	1) Clozapine + Olanzapine +		1) Clospaine + Aripiprazole +		1) Haloperidol + Clozapine +		1) Paliperidone + Fluphenazine +	
	2) Clozapine + Haloperidol		2) Olanzapine + Paliperidone +		2) Aripiprazole + Olanzapine +		2) Haloperidol + Ziprasidone +	
Justifiable Poly-Antipsychotic Therapy	77% (40/53)		61% (11/18)		79% (15/19)		66% (12/18)	

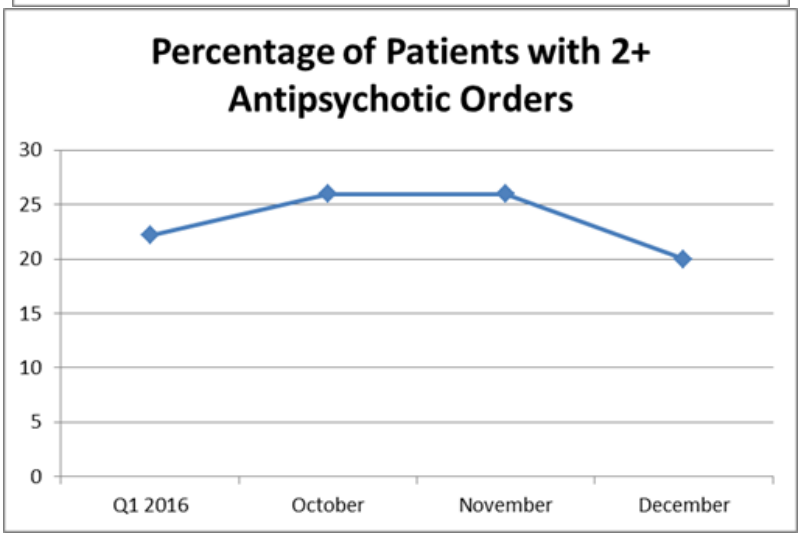
STRATEGIC PERFORMANCE EXCELLENCE

Census & Number of Patients with 0, 1, 2, 3 & 4 Orders for Antipsychotics:



Number of Patients with 2+ Antipsychotic orders per Month:





STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Metabolic Monitoring

Measure Description: Metabolic syndrome is a well-known side effect of second generation antipsychotics (SGAs). The majority of patients prescribed antipsychotics are prescribed an entity from the SGA sub-class. The purpose of this monitor is to ensure that we are monitoring, or attempting to monitor, SGA therapy appropriately for those patients prescribed SGAs.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	73%%	75%	75%	75%	75%	**75%**
Actual			71%	79%	73%	63%	**72%**

Data Analysis: The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1C.

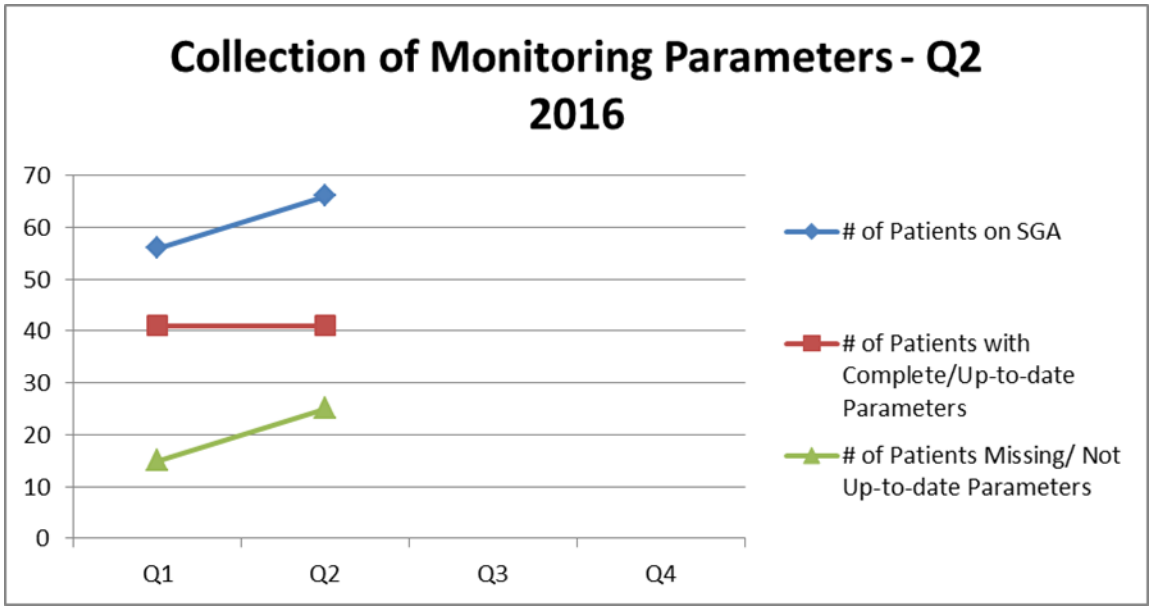
Action Plan: We will continue to monitor SGA therapy by monitoring for Metabolic Syndrome. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. Thus the goal of achieving 95% completed metabolic parameters is unrealistic and has been adjusted to a more reasonable goal of 75%. We have also started incorporating documentation of patient's refusals. This indicates that the provider is making the attempt to monitor the medication. In an attempt to streamline lab work, the Medical Staff has decided to incorporate lab work with the annual physical. This may impact this monitor going forward as data has been collected based on the most recent lab work and addition or changes in SGA therapy.

Comments: We saw a further decrease this last quarter to 63%, remaining below our goal of 75%. Of the patients that did not have complete/up-to-date parameters collected, 14% had documented refusals. For the remainder of the patients, it is likely that their annual physical is not due and thus annual labs have not been ordered.

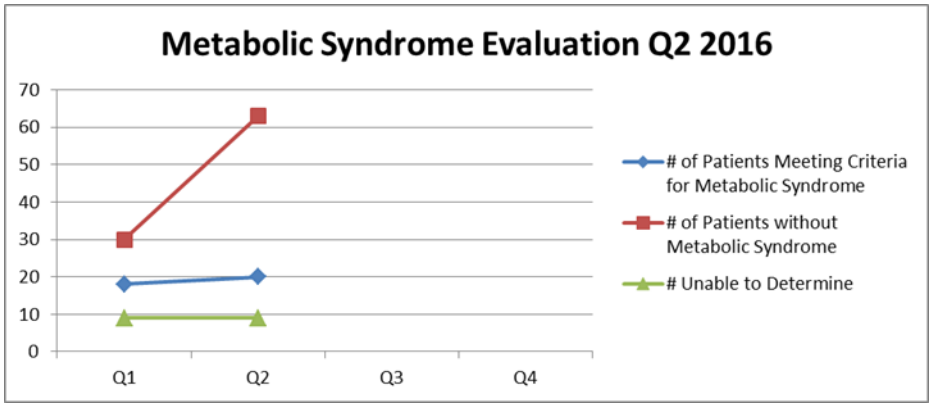
STRATEGIC PERFORMANCE EXCELLENCE

Graph/Chart:

	3Q2015	4Q2015	1Q2016	2Q2016
# of Patients on SGA	100	105	56	198
# of Patients with Complete/Up-to-date Parameters	86 (86%)	59 (56%)	41 (73%)	124 (63%)
# of Patients Missing/Not Up-to-date Parameters	14 (14%)	46 (44%)	15 (27%)	74 (37%)
# of Patients Meeting Criteria for Metabolic Syndrome	29 (29%)	32 (30%)	18 (32%)	61 (31%)
# of Patients without Metabolic Syndrome	64 (64%)	44 (42%)	30 (54%)	124 (63%)
# Unable to Determine	7 (7%)	29 (28%)	8 (14%)	27 (14%)
Documented Refusals	6 (43%)	N/A	9 (16%)	27 (14%)



STRATEGIC PERFORMANCE EXCELLENCE



III. Measure Name: Polytherapy

Measure Description: Polytherapy is defined as "combined treatment of multiple conditions with multiple medications." This differs from polypharmacy, the "treatment of a single condition with multiple medications from the same pharmacologic class or with the same mechanism of action" which our other monitor, Poly-antipsychotic therapy, addresses. Polypharmacy can lead to complex medication regimens and increases the chances of drug-drug interactions potentially negatively impacting or inhibiting another drug from exerting its intended therapeutic effect. When five or more medications are taken together there is almost a 100% chance of a drug-drug interaction. The purpose of this monitor is to evaluate polytherapy and actively discuss cases with the highest number of medications in an attempt to reduce polytherapy.

Type of Measure: Performance Improvement

Data Analysis: We have assessed a baseline group of patients with regards to their total number of medications prescribed and further broken it down to number of scheduled medications and number of PRN or "as needed" medications. Each month the patient medication profiles with the highest total number of medications for each unit will be reviewed at the Peer Review Committee to assess the potential for eliminating unnecessary medications. The number of actual profiles reviewed each month will be dependent on time constraints and presence/availability of the patient's Psychiatric and Medical providers.

Action Plan: Our plan is to continue to review patients with numerous medication orders at the monthly Peer Review Committee Meeting. An effort will be made to

obtain more information on medication adherence and PRN usage for the patients reviewed. This monitor will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees.

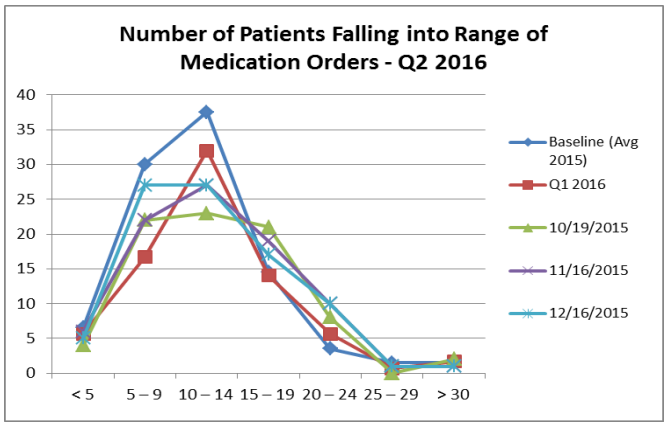
Comments: Results this quarter remain similar to last quarter. The average number of agents has likely increased due to patient specific factors including an increased number of medically fragile patients. As the number of medications per patient seems to reflect our current population, it is reasonable to transition this measure from performance improvement towards quality assurance.

Graph/Chart:

	Baseline Average	Baseline Range	Q1 2016 Average	Q1 2016 Range	10/19/15 Average	10/19/15 Range	11/16/15 Average	11/16/15 Range	12/16/15 Average	12/16/15 Range
Total Orders	12.1	0-31	12.43	0-42	13.26	1-42	12.72	1-32	13	0-31
Scheduled	4.9	0-17	6.17	0-21	6.51	0-21	6.13	1-19	6	0-20
PRNs	5.9	0-19	6.83	0-23	7.35	0-22	7.02	0-18	7	0-19

Medication Number Range	Number of Patients (Baseline)	1Q2065	10/19/15	11/16/15	12/16/15	2Q2016
< 5	7	17	4	6	5	6
5 – 9	30	50	22	22	27	17
10 – 14	38	96	23	27	27	32
15 – 19	15	42	21	19	17	14
20 – 24	4	17	8	10	10	6
25 – 29	2	2	0	1	1	1
> 30	2	5	2	1	1	2

Number of Patients Falling in to Range of Medication Orders:



STRATEGIC PERFORMANCE EXCELLENCE

Nursing

Indicator: Mandate Occurrences

Definition: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy. This creates difficulty for the employee who is required to unexpectedly stay at work up to 16 hours. It also creates a safety risk.

Objective: Through collaboration among direct care staff and management, solutions will be identified to improve the staffing process in order to reduce and eventually eliminate mandate occurrences. This process will foster safety in culture and actions by improving communication, improving staffing capacity, mitigating risk factors, supporting the engagement and empowerment of staff. It will also enhance fiscal accountability by promoting accountability and employing efficiency in operations.

Those responsible for monitoring: Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

Methods of monitoring: Monitoring would be performed by:

- Staffing Office Database Tracking System
- Human Resources Department Payroll System

Methods of reporting: Reporting would occur by one or all of the following methods:

- Staffing Improvement Task Force
- Nursing Leadership
- Riverview Nursing Staff Communication

Unit: Mandate shift occurrences

Baseline: September 2013: Nurse Mandates 14 shifts, Mental Health Worker Mandates 49 shifts

Monthly Targets: 10% reduction monthly x4 from baseline

STRATEGIC PERFORMANCE EXCELLENCE

Mandate Occurrences: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.

	New Baseline Sept 2013	3Q2015			4Q2015			3Q2015			1Q2016			Goal
		Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	
Nursing Mandates	14	6	20	11	2	4	6	2	1	8	11	8	10	10% reduction monthly x4 from baseline)
Mental Health Worker (MHW) Mandates	49	66	39	51	20	44	56	28	39	58	62	41	32	10% reduction monthly x4 from baseline)

Nursing mandates increased from 11 last quarter to 29 this quarter.
MHW mandates increased from 125 last quarter to 135 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Lower Saco

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	12 of 15	80%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	4 of 15	27%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	15 n/a	100%
5. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
6. Dental education Teaching checklist	11 of 15	73%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15 of 15	100%
8. Annual Assessment completed.	6 of 15 3 n/a	60%
9. Patient's rights signed.	11 of 15 1 ref.	80%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	11 of 15 1 n/a	80%
11. Informed Consent signed and dated	7 of 15 1 ref.	53%
12. STG Interventions are clear, simple behavioral actions for nurses	11 of 15 4 n/a	100%
13. STG for patient is behavioral and measurable	10 of 15 4 n/a	93%
14. SRC monitor sheets completed	1 of 15 14 n/a	100%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 n/a	100%
16. Safety meeting held 72 hours after coercive event	15 n/a	100%
17. Treatment plan updated after every coercive event	15 n/a	100%
18. Staff debriefing completed within 24 hrs of coercive event	15 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Upper Saco

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	15 of 15	100%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	12 of 15	80%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	1 of 15 13 n/a	93%
5. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
6. Dental education Teaching checklist	14 of 15	93%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	14 of 15	93%
8. Annual Assessment completed.	9 of 15	60%
9. Patient's rights signed.	14 of 15 1 ref.	100%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	15 of 15	100%
11. Informed Consent signed and dated	14 of 15 1 ref.	100%
12. STG Interventions are clear, simple behavioral actions for nurses	15 of 15	100%
13. STG for patient is behavioral and measurable	11 of 15	73%
14. SRC monitor sheets completed	15 n/a	100%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 n/a	100%
16. Safety meeting held 72 hours after coercive event	15 n/a	100%
17. Treatment plan updated after every coercive event	15 n/a	100%
18. Staff debriefing completed within 24 hrs of coercive event	15 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Lower Kennebec

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	13 of 15	87%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	2 of 15	13%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	1 of 15 10 n/a	73%
5. Multidisciplinary Teaching checklist active being completed.	15 of 15	100%
6. Dental education Teaching checklist	14 of 15 1 ref.	100%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	14 of 15 1 loc.	100%
8. Annual Assessment completed.	15 of 15	100%
9. Patient's rights signed.	6 of 15 3 loc.	60%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	14 of 15	93%
11. Informed Consent signed and dated	4 of 15 3 loc.	47%
12. STG Interventions are clear, simple behavioral actions for nurses	15 of 15	100%
13. STG for patient is behavioral and measurable	14 of 15	93%
14. SRC monitor sheets completed	14 n/a	93%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	1 of 15 13 n/a	93%
16. Safety meeting held 72 hours after coercive event	1 of 15 13 n/a	93%
17. Treatment plan updated after every coercive event	13 n/a	87%
18. Staff debriefing completed within 24 hrs of coercive event	2 of 15 13 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Upper Kennebec

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	11 of 15	73%
2. STGs/ Interventions relate directly to content of GAP note.	13 of 15	87%
3. Weekly Summary note completed.	9 of 15	60%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	1 of 15 14 n/a	100%
5. Multidisciplinary Teaching checklist active being completed.	14 of 15 1 n/a	100%
6. Dental education Teaching checklist	13 of 15 1 n/a	93%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15 of 15	100%
8. Annual Assessment completed.	10 of 15 2 n/a	80%
9. Patient's rights signed.	10 of 15 1 ref., 1 loc.	80%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	10 of 15 3 n/a	87%
11. Informed Consent signed and dated	10 of 15 1 loc.	73%
12. STG Interventions are clear, simple behavioral actions for nurses	10 of 15 5 n/a	100%
13. STG for patient is behavioral and measurable	9 of 15 5 n/a	93%
14. SRC monitor sheets completed	15 n/a	100%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 n/a	100%
16. Safety meeting held 72 hours after coercive event	15 n/a	100%
17. Treatment plan updated after every coercive event	15 n/a	100%
18. Staff debriefing completed within 24 hrs of coercive event	15 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2015

Total – All Units

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	51 of 60	85%
2. STGs/ Interventions relate directly to content of GAP note.	58 of 60	97%
3. Weekly Summary note completed.	27 of 60	45%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	3 of 60 52 n/a	92%
5. Multidisciplinary Teaching checklist active being completed.	57 of 60 1 n/a	97%
6. Dental education Teaching checklist	52 of 60 1 ref., 1 n/a	90%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	58 of 60 1 loc	98%
8. Annual Assessment completed.	40 of 60 5 n/a	75%
9. Patient's rights signed.	41 of 60 4 loc., 3 ref.	80%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	50 of 60 4 n/a	90%
11. Informed Consent signed and dated	35 of 60 4 loc., 2 ref.	68%
12. STG Interventions are clear, simple behavioral actions for nurses	51 of 60 9 n/a	100%
13. STG for patient is behavioral and measurable	44 of 60 9 n/a	88%
14. SRC monitor sheets completed	1 of 60 58 n/a	98%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	1 of 60 58 n/a	98%
16. Safety meeting held 72 hours after coercive event	1 of 60 58 n/a	98%
17. Treatment plan updated after every coercive event	58 n/a	97%
18. Staff debriefing completed within 24 hrs of coercive event	2 of 60 58 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient Services (OPS)

Responsible Party: Lisa Manwaring, Director

I. Measure Name: Admission Assessments

Measure Description: Within 5 business days of admission initial assessments from Psychiatry, Psychosocial, and Nursing will be complete and in the chart. All three will need to be present to count.

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of assessments completed on time	FY 2015 0% 0/4	85%	85%	85%	85%	**85%**
Actual			0% 0/3	0% 0/5			**0% 0/8**

Data Analysis: We had one chart with all three assessments this quarter but one was late. This quarter we had five admissions. Three charts had two out of three assessments.

Action Plan: To review data results with the OPS staff to ensure compliance.

Comments: To provide education and admission packets with assessment reminders to help facilitate compliance.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Responsible Party: Samantha St. Pierre, Peer Support Coordinator

Indicator: Inpatient Consumer Survey Return Rate

Definition: There is a low number of satisfaction surveys completed and returned once offered to patients due to a number of factors.

Objective: To increase the number of surveys offered to patients, as well as increase the return rate.

Those responsible for Monitoring: Peer Support Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Peer Support Staff will be responsible for offering surveys to patients and tracking them until the responsibility can be assigned to one person.

Methods of Monitoring:

- Biweekly supervision check-ins
- Monthly tracking sheets/reports submitted for review

Methods of Reporting:

- Patient Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

Unit: All patient care/residential units

Baseline: Determined from previous year's data.

Quarterly Targets: Quarterly targets vary based on unit baseline with the end target being 50%.

STRATEGIC PERFORMANCE EXCELLENCE

Survey Return Rate	Unit	Baseline	Target	3Q2015	4Q2015	1Q2016	2Q2016	YTD
The inpatient consumer survey is the primary tool for collecting data on how patients feel about the services they are provided at the hospital.	**LK**	15%	50%	37%	20%	41% 7/17	23% 3/13	**30%**
	LS	5%	50%	62%	0%	0% 0/21	54% 7/13	**29%**
	UK	45%	50%	26%	27%	18% 3/17	25% 4/16	**24%**
	US	30%	50%	100%	100%	88% 7/8	100% 7/7	**97%**
	Overall						**43%**	**45%**

Comments:
Percentages are calculated based on the number of people eligible to receive a survey vs. the number of people who completed the surveys.

Inpatient Consumer Survey Results:

#	Indicators	3Q 2015	4Q 2015	1Q 2016	2Q 2016	Average
1	I am better able to deal with crisis.	75%	69%	69%	82%	**74%**
2	My symptoms are not bothering me as much.	73%	69%	79%	77%	**73%**
3	The medications I am taking help me control symptoms that used to bother me.	71%	77%	75%	70%	**73%**
4	I do better in social situations.	73%	63%	71%	64%	**68%**
5	I deal more effectively with daily problems.	75%	71%	73%	83%	**76%**
6	I was treated with dignity and respect.	69%	73%	71%	65%	**70%**
7	Staff here believed that I could grow, change and recover.	74%	63%	69%	62%	**67%**
8	I felt comfortable asking questions about my treatment and medications.	71%	54%	68%	68%	**65%**
9	I was encouraged to use self-help/support groups.	77%	56%	72%	75%	**70%**
10	I was given information about how to manage my medication side effects.	60%	63%	68%	53%	**61%**
11	My other medical conditions were treated.	69%	65%	65%	69%	**67%**
12	I felt this hospital stay was necessary.	50%	67%	65%	48%	**58%**

STRATEGIC PERFORMANCE EXCELLENCE

#	Indicators	3Q 2015	4Q 2015	1Q 2016	2Q 2016	Average
13	I felt free to complain without fear of retaliation.	54%	56%	69%	60%	**60%**
14	I felt safe to refuse medication or treatment during my hospital stay.	49%	54%	62%	46%	**53%**
15	My complaints and grievances were addressed.	63%	65%	63%	55%	**62%**
16	I participated in planning my discharge.	66%	38%	75%	43%	**56%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	52%	38%	63%	30%	**46%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	47%	54%	63%	32%	**49%**
19	The surroundings and atmosphere at the hospital helped me get better.	61%	60%	68%	63%	**63%**
20	I felt I had enough privacy in the hospital.	66%	58%	64%	61%	**62%**
21	I felt safe while I was in the hospital.	72%	69%	62%	62%	**66%**
22	The hospital environment was clean and comfortable.	74%	74%	66%	63%	**69%**
23	Staff were sensitive to my cultural background.	65%	65%	61%	52%	**61%**
24	My family and/or friends were able to visit me.	68%	73%	69%	64%	**69%**
25	I had a choice of treatment options.	60%	52%	64%	56%	**58%**
26	My contact with my doctor was helpful.	55%	62%	66%	58%	**60%**
27	My contact with nurses and therapists was helpful.	57%	53%	66%	64%	**60%**
28	If I had a choice of hospitals, I would still choose this one.	54%	60%	55%	45%	**54%**
29	Did anyone tell you about your rights?	74%	77%	71%	51%	**68%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%	69%	63%	54%	**62%**
31	Do you know someone who can help you get what you want or stand up for your rights?	77%	77%	74%	77%	**76%**
32	My pain was managed.	65%	75%	62%	75%	**69%**
	Overall Score	**65%**	**63%**	**67%**	**63%**	**65%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Responsible Party: Michael Migliore, Director of Pharmacy

I. **Measure Name: Controlled Substance Loss Data**

Measure Description: Daily and monthly comparison of Pyxis vs CII Safe Transaction Report.

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Pharmacy	0.19%	0%	0%	0%	0%	0%
Actual			0%	0%			0%

Data Analysis: None of the 6 controlled substance discrepancies were due to anything other than simple miscounts. All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the second quarter.

Action Plan: Remain vigilant and continue to educate staff on proper automated dispensing cabinet procedures to avoid the creation of discrepancies.

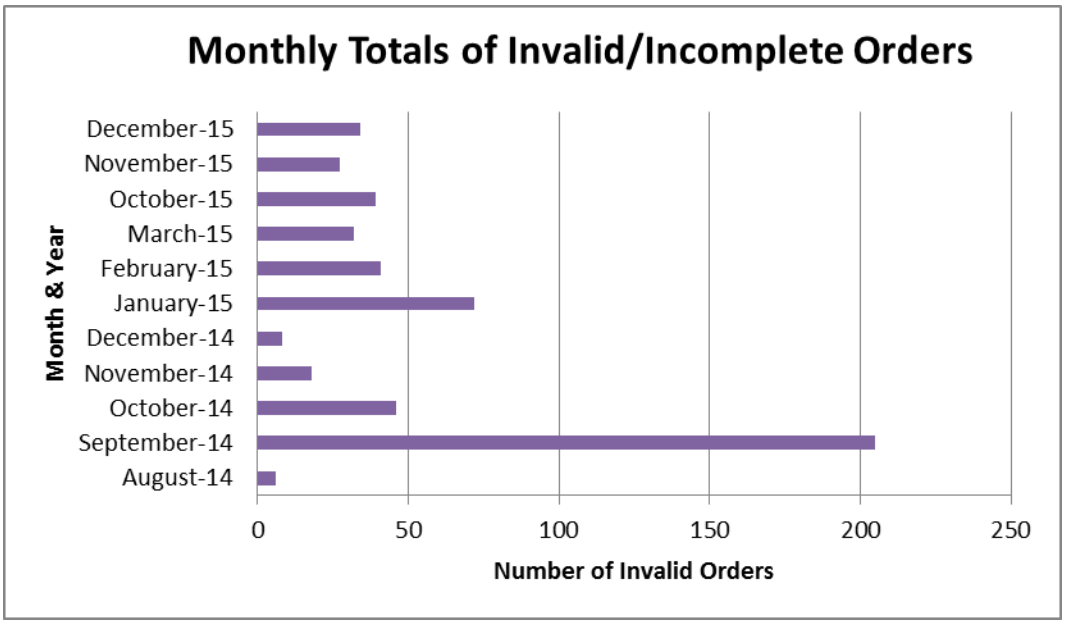
Comments: Baseline for FY2014 was 0.88%. There has been a great improvement during FY2015 with a baseline of 0.19% and this is expected to continue throughout FY2016.

STRATEGIC PERFORMANCE EXCELLENCE

II. **Measure Name: Invalid Orders**

Measure Description: Incomplete/invalid orders.

Type of Measure: Performance Improvement



Background: Whenever an invalid order is received in the pharmacy it is documented, copied, and returned to the appropriate unit so that the prescriber can remedy it. The staff pharmacist then makes contact with the unit to ensure they are aware of the particular issue that invalidated the order. The hospital has a zero tolerance policy for invalid orders. Each order must include: drug name, strength, administration route, dosing frequency, provider signature, order time and date, accurate allergy and adverse drug reaction information, and indication. The data collection system was enhanced during the last quarter when there was a significant number of new staff in the pharmacy.

Data Analysis: For the second quarter the number of invalid orders has remained consistent, averaging 33 invalid orders per month, compared to a baseline average of 48. The most common reason for invalid orders was incorrect allergy and adverse drug reaction information on the order forms, closely followed by missing indications.

Action Plan: Whenever an incomplete order is received by the pharmacy the staff pharmacist contacts the unit, and whenever possible the prescriber themselves, immediately for timely resolution. Whenever not a case of simple oversight, continue providing re-education to providers to ensure optimal patient care.

STRATEGIC PERFORMANCE EXCELLENCE

III. **Measure Name: Veriform Medication Room Audits**

Measure Description: Monthly comprehensive compliance audits of 38 criteria

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	All	100%	100%	100%	100%	100%	**100%**
Actual			100%	100%			**100%**

Data Analysis: The medication room audits have been concluded for quarter two without completion deficiencies.

Audit Compliance Findings: The audits for all the units have been completed for the quarter. Criteria found upon inspection that could be improved:

Action Plan: No deficiencies were noted with pharmacy's completion of the medication room audits. Pharmacy staff will continue to operate to maintain 100% completion and will continue reporting any noted deficiencies to nursing staff.

Comments: The previous version of this report noted that the audits were 97%, however that was a compliance statistic. Pharmacy's responsibility is to ensure the completion of the medication room audits and for that measure we remain at a steadfast 100%.

STRATEGIC PERFORMANCE EXCELLENCE

IV. **Measure Name: Fiscal Accountability**

Measure Description: Monthly and tracking of dispensed discharge prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**3Q 2015**	**4Q 2015**	**1Q 2016**	**2Q 2016**	**YTD**
Actual	All	$15764 for 861 Rx's	$4474 for 295 Rx's	$5266 for 261 Rx's	$5281 for 368 Rx's	$3719 for 312 Rx's	**$18740 for 1236 Rx's**

Data Analysis: Riverview Psychiatric Center has an Extended Hospital Pharmacy license, meaning it can dispense to both in and outpatients. The majority of the outpatient prescriptions are for a 7-day supply of discharge medications. Special approval is required from administration when a great than 7 day supply is needed. The discharge prescriptions serve to cover the patient's needs until they are able to obtain medications in the community.

Action Plan: Advanced discharge planning would allow for patients to obtain prescription coverage prior to discharge. This would dramatically reduce the volume of outpatient prescriptions provided by the pharmacy and thereby decrease expenditures.

Comments: Riverview can save money by working on the action plan above.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology

Responsible Party: Arthur DiRocco, Ph.D., Director of Psychology

I. Measure Name: Outpatient Readiness Scale (ORS)

Measure Description: 90% of NCR inpatients will have an ORS completed and updated every 6 months

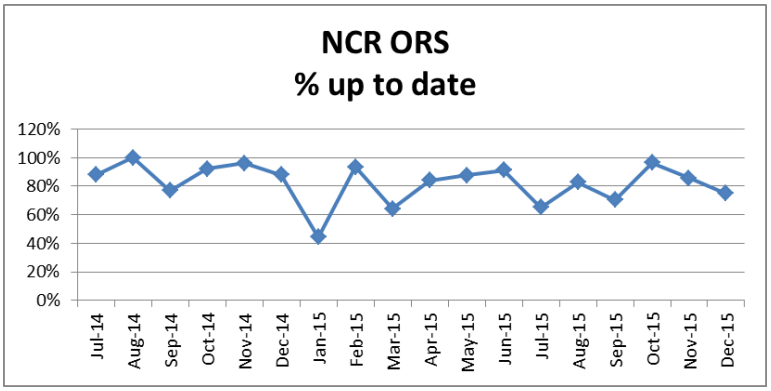
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**Q1-2016**	**Q2-2016**	**Q3-2016**	**Q4-2016**	**YTD**
Target	Percent of assessments up to date	4Q FY 2015 21/24 87%	75/100 75%	90/100 90%	90/100 90%	90/100 90%	**360/400 90%**
Actual			53/73 73%	71/83 86%			**124/156 79%**

Data Analysis: Assessments of NCR patients using the ORS was initiated in January 2014. The population of interest was fully evaluated by July 2014. Updated assessments of NCR patients since that time have varied from a low of 40% in January 2015 to a high of 96% in October 2015. The average for the 4th quarter 2015 was 87%; in comparison, the average for the 2nd quarter 2016 was 86%. Due to relatively low numbers, the absence of one score can drop the percentage rate by up to 4 percent. As an example, in October 2015 the rate was 96%.

Action Plan: Continue to encourage teams to take initiative to complete the ORS. Tracking of due dates needs to be accomplished to avoid times where patients are not up to date.

Comments: This data is of inpatients only



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Outpatient Readiness Scale (ORS)

Measure Description: The ORS will be completed for those patients who reside in the community and are receiving services through OPS. Target is 90% of outpatient services recipients will have ORS completed and updated every 6 months.

Type of Measure: Performance improvement

Results							
	Unit	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Target	Percent of OPS recipients evaluated with ORS	2Q FY 2015 New initiative 2%	75/100 75%	75/100 75%	75/100 75%	75/100 75%	**300/400 75%**
Actual			5/23 22%				**5/23 22%**

Data Analysis: This is a new initiative and will require training and follow-up with the OPS treatment team. Preliminary efforts have helped produce modest results in the first month.

Action Plan: Psychology staff who work with the OPS treatment team will prompt the team to complete the ORS on each OPS recipient.

III. Measure Name: Brief Intake Assessment

Measure Description: The target is 90% of hospital admissions will have a Brief Intake Assessment completed within 7 days of admission.

Type of Measure: Performance Improvement

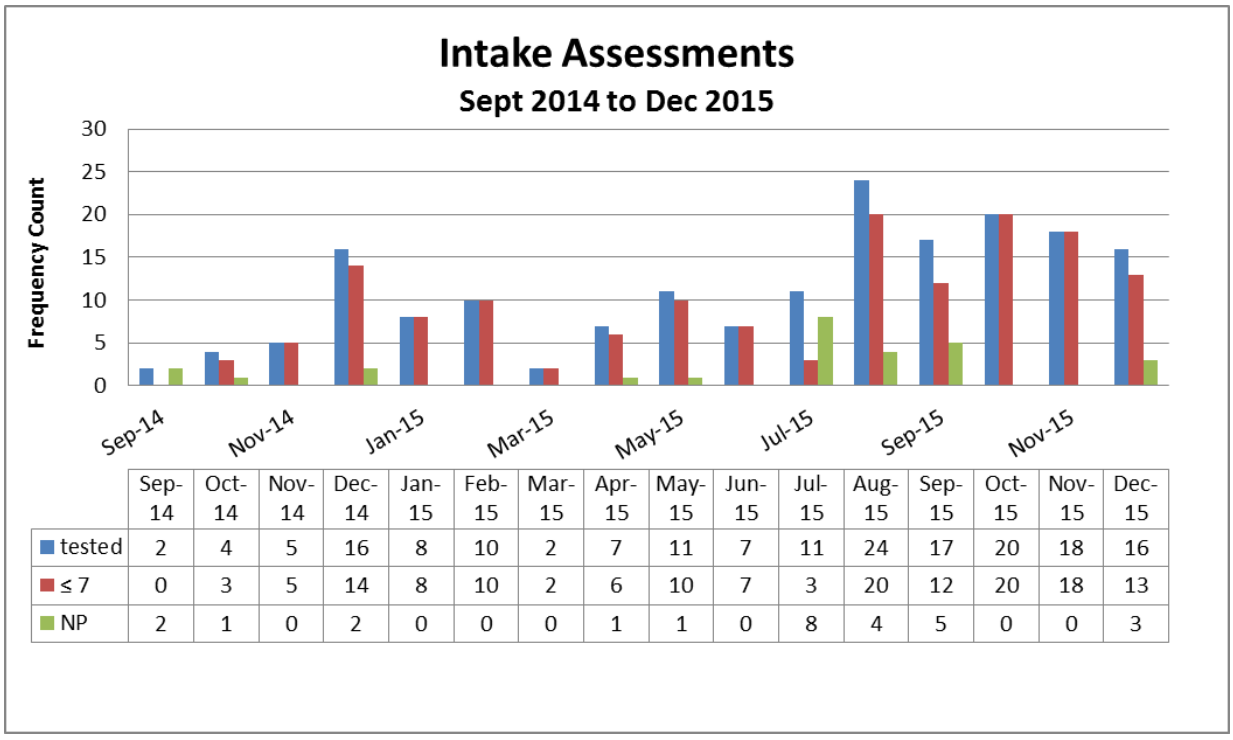
Results							
	Unit	**Baseline**	**Q1-16**	**Q2-16**	**Q3-16**	**Q4-16**	**YTD**
Target	Percent of assessments completed within 7 working days	4Q FY 2015 25/45 55% tested	75/100 75%	75/100 75%	75/100 75%	75/100 75%	**300/400 75%**
Actual			52/64 81%	54/59 92%			**106/123 86%**

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: **T**he data as presented above represents the testing of all admissions over the quarter. Baseline during 4Q 2015 was only 55% of admissions. While the goal is to establish a 90% rate of assessment on intake, there is also a sub-goal to have the assessments completed and shared with the treatment team within 7 days. The charts below show the outcome of that effort.

Action Plan: Maintain this goal but increase the value of the information by assuring that staff are briefed on the results during treatment team meeting. Psychology staff will ensure that the primary care provider is given a copy of the assessment and that it is shared with the treatment team in a timely manner.

Comments: The chart below shows total number of assessments and breaks down those less than 7 days and those completed beyond 7 days (labeled NP)



	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
tested	2	4	5	16	8	10	2	7	11	7	11	24	17	20	18	16
≤ 7	0	3	5	14	8	10	2	6	10	7	3	20	12	20	18	13
NP	2	1	0	2	0	0	0	1	1	0	8	4	5	0	0	3

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

(Occupational Therapy, Therapeutic Recreation, Vocational Services, Chaplaincy, Patient Education)

Responsible Party: Janet Barrett, CTRS, Director of Rehabilitation Services

I. Measure Name: Occupational Therapy Service Orders

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients receiving Occupational Therapy Services have a doctor's order and referral sheet completed before services are initiated.

Methodology: Each quarter Rehabilitation Services Director will audit the Occupational Therapy Referral Log and review the list of all patients receiving services to ensure a doctor's order for the service has been written and a referral to OT was completed before the patient began receiving services.

The numerator will be the number of OT Service referrals that include the required MD order, the denominator will be the total number of OT Service referrals received.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient receiving OT services has an MD order	FY 2015 97%	100%	100%	100%	100%	**100%**
Actual			100% 25/25	100% 29/29			**100% 54/54**

Data Analysis: In review of Occupational Therapy Services Log all patients referred for services from October 1, to December 31, 2015 had both the referral sheet completed as well at the doctor's order attached to it.

Action Plan: Review the results of the audit with Occupational Therapy staff.

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II. Measure Name: Vocational Services Documentation

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients engaged in the Vocational Rehabilitation Program will have updated treatment plans and weekly documentation on the progress towards addressing the intervention outlines in the treatment plan.

Methodology: Each quarter Rehabilitation Services Director will audit the charts of the patients involved in the Vocational Rehabilitation Program to review treatment plans and progress notes to ensure they are being completed in a timely manner and updated on a regular basis.

The numerator will be the number of patient charts with the required documentation and the denominator will be the total number of patients in the Vocational Rehabilitation Program.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient working in the Voc. Rehab. Program has required documentation	60%	100%	100%	100%	100%	**100%**
Actual			50% 6/12	81% 9/11			**65%** **15/23**

Data Analysis: Nov/Dec 2015 & Jan 2016- Charts were audited using the Rehab. Services – Vocational Services tool. There were only 2 charts in which a weekly note was not done on time.

Action Plan: Continue with the monthly audits to assist with attaining the goal of 100 % so that the Vocational documentation can reach the goal of 4 consecutive quarters of 100%

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Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. Measure Name: Grounds Safety & Security Incidents

Measure Description: Safety/Security incidents occurring on the grounds at Riverview, Grounds being defined as "outside the building footprint of the facility; being the secured yards, parking lots, pathways surrounding the footprint, unsecured exterior doors, and lawns." Incidents being defined as "Acts of thefts, vandalism, injuries, mischief, contraband found, and safety/security breaches." These incidents shall also include "near misses, being of which if they had gone unnoticed, could have resulted in injury, an accident, or unwanted event".

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**Total**
Target	# of Incidents	*Baseline of 10	16	4	2	4	**26**
Actual			4	2	4	2	**12**

Summary of Events: The Q2 Target was (4). Our actual number was (2). We exceeded our goal! We have not had any issues this quarter with state owned pickup trucks and the contraband they frequently contained. We have been working with Capitol Police, Fleet Management and the Department of Conservation (agency the trucks are assigned to). There has been significant improvement in how often we are finding contraband items in these trucks. We will continue to work with all parties as we seek to resolve this issue. Another problem area appears to be our fleet of rental vehicles. Even though Security asks every person who returns a vehicle if it is locked, we had two incidents of cars left unlocked. These vehicles contain state credit cards and other items of value. Our approach has been to treat this as a supervisory issue. Although we had no issues this quarter a new system was implemented, by maintenance, for checking cars in and out. We will monitor and remain vigilant as we all get used to the new system. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the patients. The reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Securitas continue to prove its worth with regard to

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Security's presence and patrol techniques. The stability and longevity of our Security staff along with its cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

Safety & Security Incidents:

Event	Date	Time	Location	Disposition	Comments
1. Safety Concern (Unlocked, garbage dumpster, contraband in dumpster)	11/12/15	0208	Rear of Building	Relocked Dumpster	Dumpster locking arm out of position. Repositioned and relocked.
2. Security Concern (Suspicious person outside near front lobby entrance)	11/26/15	1303	Front of Building	Capitol Police ordered the person to leave	Male was walking aimlessly in front of the lobby area. He was contemplating coming in to visit his wife (a patient here). The man admitted to drinking and was acting "strange". Capitol Police arrived and took over the situation.

STRATEGIC PERFORMANCE EXCELLENCE

Social Work

Responsible Party: Stephanie George-Roy, LCSW, Director of Social Work

I. Measure Name: Social Work Community Connections

Measure Description: The Social Work Department will ensure that 100% of the time patients will be offered to have social work assist them in securing correctional, familial, and natural or community provider participation in their treatment during their admission to Riverview Psychiatric Center to facilitate continuity in discharge planning back to the community.

Type of Measure: Quality Assurance

Methodology: The Social Worker will engage with patient during Service Integration Meeting within 3 days of admission to ensure that the patient is informed of the opportunity to have external self-identified recovery supports participate in their treatment services at RPC.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient is offered assistance with securing identified recovery supports from the community	N/A new for FY 16	100%	100%	100%	100%	**100%**
Actual			100% 61/61	100% 47/47			**100% 108/108**

Data Analysis: In chart audits completed over the second quarter 47 patients completed the Service Integration Meeting with their assigned social worker and were asked to identify recovery supports from the community. Two patients declined (49 total admissions in the quarter) to participate in the Service Integration meeting and declined on follow up.

Action Plan: Review the results of the audit with Social Work staff and continue with chart audits and documenting results.